SUSTAINABLE MANAGEMENT OF THE HIV/AIDS RESPONSE AND TRANSITION TO TA PROJECT (USAID - SMART TA)

FY12

Annual Performance Report (October 2011 – September 2012)

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
ART	Antiretroviral therapy
ARV	Antiretroviral
CA	Cooperative Agency
CCIHP	Centre for Creative Initiatives in Health and Population
CCM	Country Coordinating Mechanism
CCMS	Community Case Management and Support
CDC	(United States) Centers for Disease Control and Prevention
CHP	Center for Community Health Promotion
CMT	Clinical Management Training
CoP	Chief of Party
CoPC	Continuum of Prevention-to-Care
CSO	Civil Society Organization
CUP	Condom Use Program
DST	Department of Science and Training
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, TB and Malaria
GIS	Geographic Information System
GVN	Government of Vietnam
HCMC	Ho Chi Minh City
HPI	Health Policy Initiative
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HMU	Hanoi Medical University
IBBS	Integrated Biologic and Behavioral Surveillance
ICT	Information and Communications Technology
IDU	Injecting Drug User

IMF	International Monetary Fund
IPT	Isoniazid Prevention Therapy
KNCV	Dutch TB Foundation
LDS	Low Dead Space (needles)
MARP	Most-At-Risk Population
MF	Ministry of Finance
MMT	Methadone Maintenance Therapy
MOH	Ministry of Health
MOLISA	Ministry of Labor, Invalids and Social Affairs
MPI	Ministry of Planning and Investment
MSM	Men who have Sex with Men
OI	Opportunistic Infection
OPC	Outpatient clinic
OR	Operational Research
PAC	Provincial AIDS Center
Pathways	Pathways for Participation
PEPFAR	The President's Emergency Plan for AIDS Relief
PHR	Partners for Health Research
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PLP	Pathways Lead Partners
QI	Quality Improvement
SCDI	Supporting Community Development Initiatives (Center for)
SAMHSA	Substance Abuse and Mental Health Services Administration
SMART TA	Strategic Management of the HIV/AIDS Response and Transition to TA Project
SI	Strategic Information
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance

TAB	Transition Advisory Board
TB	Tuberculosis
TMA	Total Market Approach
VAAC	Vietnam Administration for HIV/AIDS Control
VNIS360	FHI 360 Vietnam Information System

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SMART TA

ANNUAL PERFORMANCE REPORT (OCTOBER 2011 – SEPTEMBER 2012)

PROGRAM OVERVIEW

The USAID *Sustainable Management of the HIV/AIDS Response and Transition to Technical Assistance Project* – or "SMART TA" – is a five-year, 45 million USD initiative that strives to ensure the provision of quality comprehensive and sustainable HIV services through a strengthened national response. It is designed to contribute directly to the targets identified in the *National Strategy on HIV/AIDS Prevention and Control in Vietnam* and the *Partnership Framework Between the Government of the United States of America and the Government of the Socialist Republic of Vietnam for HIV/AIDS Prevention and Control.*

FHI 360 works in collaboration with the Government of Viet Nam (GVN), the President's Emergency Plan for AIDS Relief (PEPFAR), other key stakeholders and over 30 local agencies to implement SMART TA and deliver results across three main strategic objectives: (1) delivery of quality HIV services within the continuum of HIV prevention and care (CoPC); (2) transitioning of financial, administrative and technical ownership of CoPC services to the GVN and other stakeholders; and (3) strengthening of technical capacity and country ownership to sustain quality HIV services. The guiding principles of SMART TA are country ownership, sustainability, participation and accountability, quality improvement, and coordination and collaboration.

Over a five-year period, SMART TA will work towards the following key results:

- 100% of SMART TA-supported CoPC interventions, partners and sites transitioned to the GVN and local partners, with resources coming from the government, other donor sources, and efficiency gains
- Sustainable CoPC models for medium- and low-resourced provinces operationalized, with innovative, efficient, evidence-based approaches extended across the country
- Quality improvement (QI) and technical capacity building assistance provided, with local institutions identified and strengthened to deliver this assistance
- Strengthened country ownership of the HIV response, including an enhanced profile of CSOs and MARP networks (in partnership with the Pathways for Participation initiative)

- Direct service provision (prior to transitioning USAID-financially supported implementation through SMART TA) for the following:
    - 32,338 female sex workers (FSWs), 30,740 people who inject drugs (IDUs) and 17,751 men who have sex with men (MSM) will be reached with HIV prevention services in targeted PEPFAR provinces
    - 5,035 IDUs will have received MMT across 20 sites, 5 of which will be fully integrated with HIV care and treatment services
    - 39,120 PLHIV and family members will have received umbrella care, including 19,560 adults and children living with HIV enrolled in HIV care and treatment services across 34 CoPC sites, of which 16,300 received antiretroviral therapy (ART)

SMART TA will assist the GVN to transition strategic information efforts and core and supplementary packages of HIV prevention and care services in focus provinces and beyond. Over the course of the initiative, SMART TA will (a) assess the capacity of the GVN and civil society organizations (CSOs) [the latter in collaboration with Pathways] to implement individualized CoPC interventions for each province and develop annual capacity-building plans, (b) collaborate on the development of cost-effective CoPC models and service packages that can be replicated using local resources, (c) integrate services that maximize existing resources and meet clients' needs, (d) strengthen national, provincal and district CoPC referral networks, (e) strengthen data use for program planning and revision, and (f) ensure quality across implementing sites and implementing agencies.

The transition of financial, administrative and technical responsibilities for the implementation of HIV CoPC programs supported by SMART TA will require national and provincial consensus building, capacity assessment, standardization of models and service packages, development of individual provincial transition plans, technical support, and ongoing monitoring and quality improvement. SMART TA will work with USAID, the Ministry of Health (MOH) and the Vietnam Administration for HIV/AIDS Control (VAAC), the Ministry of Labor, Invalids and Social Affairs (MOLISA), the Ministry of Planning and Investment (MPI), the Ministry of Finance (MF), Provincial AIDS Centers (PACs), CSOs, Pathways partners, PEPFAR and other stakeholders to transition 100% of the current FHI 360 implementation portfolio to the GVN and relevant CSOs by Year 5.

This document constitutes SMART TA's FY12/COP11 Annual Performance Report for the period 01 October 2011 to 30 September 2012. The following sections outline:

- Year One overall accomplishments and lessons learned
- Progress towards strategic objectives and program indicators
- Project management and personnel

- Information on cost overruns
- Performance indicator data table
- SMART TA stories

YEAR ONE ACCOMPLISHMENTS AND LESSONS LEARNED

Figure 1: SMART TA Technical Approach

SMART TA strives to achieve results across three main strategic objectives:

1. *Deliver quality HIV services within the CoPC.* SMART TA collaborates with partners on the development of efficient and effective CoPC core and supplementary service packages that can be replicated in medium- and low-resourced provinces. The program endeavors to ensure quality across implementing programs while transitioning ownership to the GVN and CSOs.

2. *Transition financial, administrative and technical ownership of CoPC services.* SMART TA works with USAID/PEPFAR to incrementally transition financial and technical responsibility for CoPC programs to the GVN and CSO partners, based on systematic assessments of capacity, resources and effective implementation models that match local HIV epidemic needs. Throughout the life of the agreement, SMART TA will provide the MOH, line ministries, PACs/PHS and CSOs with support to guarantee the success of this transition and will work to harmonize transitions processes with CDC/Life-GAP and GFATM.

3. *Strengthen technical capacity and country ownership.* SMART TA works to strengthen the institutional capacity and develop the human capital of targeted GVN and CSO partners (particularly those supported by Pathways) to manage, implement and sustain the HIV response. Technical assistance, capacity building measures and QI processes will be

increasingly led and delivered by local organizations, institutions and providers over the life of the program.

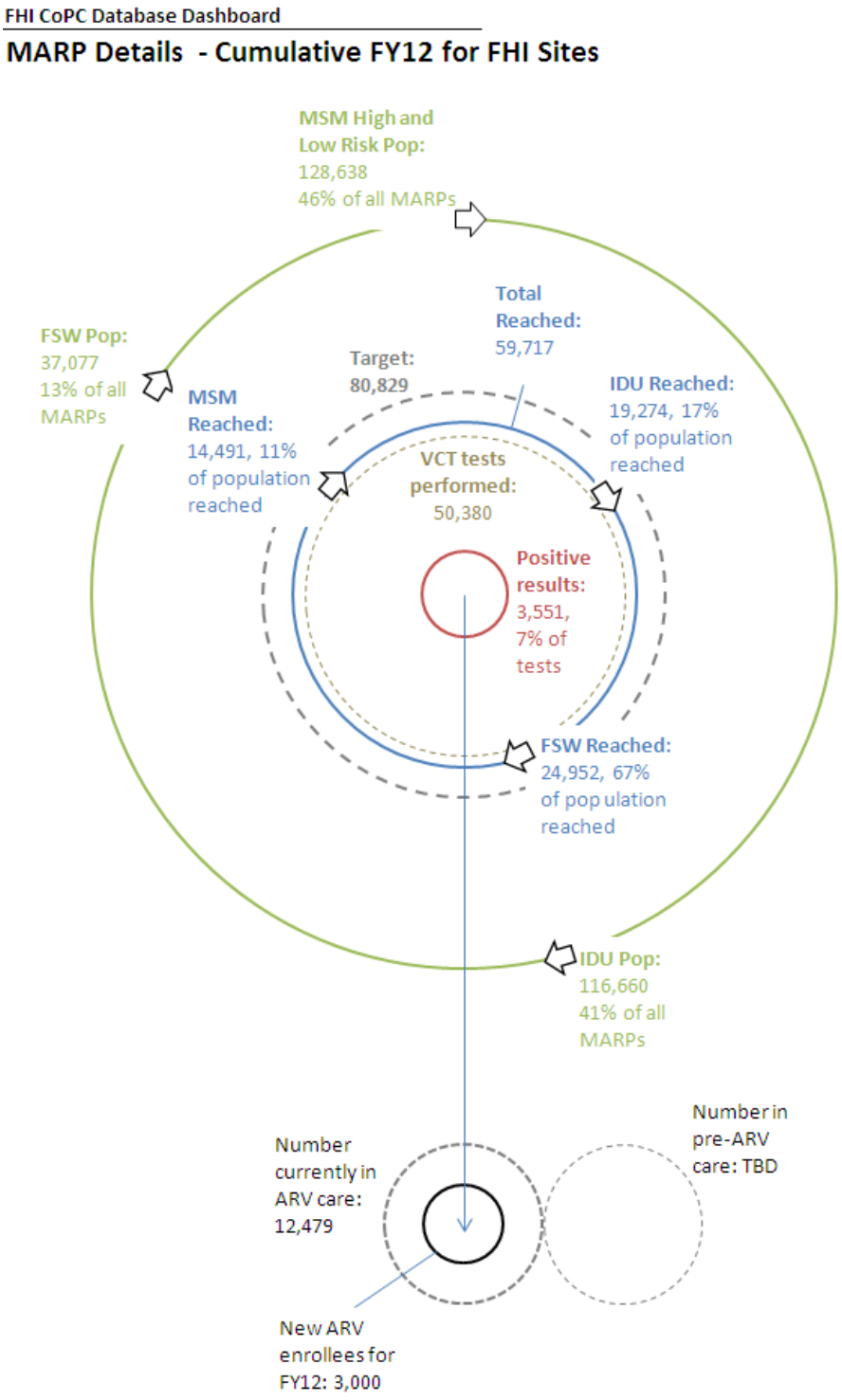
SMART TA activities are embedded within a context of Readiness – Action – Ownership. *Readiness* includes developing a better understanding of the service delivery/transitioning and TA context; strengthening partnerships, structures and systems; streamlining SMART TA supported services; working towards fostering consensus on priority actions and core service packages; and field testing approaches. *Action* involves actualizing transition strategies and structures; implementing pilots; providing targeted TA; and building capacities. *Ownership* includes institutionalizing TA; transferring financial and programmatic responsibilities; and supporting the GVN to plan for and ensure adequate budgeting, HR and systems for a "context-driven" quality response.

The Readiness – Action – Ownership framework emphasizes the relative importance of components during different phases of the program:

Figure 2: SMART TA Readiness – Action – Ownership Framework

Key results from Year One (COP11 or FY12) SMART TA activities are shown in the following continuum of prevention, care and treatment dashboard:

Figure 3| FY12/COP11 Key Accomplishments Dashboard



Careful interpretation of the dashboard format is needed. Results will be further analyzed in the annual report narrative. Please note:

1. Period of data is from October 2011 to September 2012.
2. Size estimation data (from March 2011) is presented for provinces with SMART TA supported sites and activities. Medium size estimate numbers were used.
    a. Dashboard includes high and low-risk MSM in the size estimations, though SMART TA prioritizes high-risk MSM clients.
3. HTC test numbers (including positives) do not count individuals but rather number of tests performed and received by clients. Many clients test multiple times per year as per recommendations. Other clients may test twice, with the hope that the second test will come back with different results, etc.
    a. Clients may come to HTC testing centers for reasons other than having been reached by an outreach worker.
    b. HTC numbers also count sex partners, which make up almost 40% of the overall number of HTC tests.

In Year One (COP11 or FY12) of the initiative, SMART TA also realized the majority of its benchmark targets:

Table 1| FY12/COP11 Key Accomplishments Table

Performance Indicator/Output	FY12 Target	Annual Achievements
Deliver quality HIV services wihin the CoPC		
MARPs reached with individual and/or small group level HIV prevention interventions	80,829	59,717
Number of clinics offering opioid substitution therapy (MMT)	17	17
Number of people who inject drugs on opioid substitution therapy	3,200	3,606
Number of individuals who received testing and counseling services for HIV and received their test results	71,500	50,380
Number of HIV-positive adults and children receiving a minimum of 1 clinical service	15,540	16,778
Number of adults and children with advanced HIV infection receiving antiretroviral therapy	12,950	12,479
Number of surveillance activities carried out with	3	3

Performance Indicator/Output	FY12 Target	Annual Achievements
technical and/or financial assistance from SMART TA		
Number of operational research studies conducted with technical and/or financial assistance from SMART TA	4	1
Transition financial, administrative and technical ownership of CoPC services		
Province CoPC reviews completed in SMART TA-supported areas	11	11
CoPC core/supplementary service packages drafted with all relevant stakeholders	Drafts completed and consultations undertaken	Drafts completed and consultations undertaken
Transitions bodies established and operational	12	PEFAR leading process
Sub-agreement efficiency gains made	20% across each sub-agreement	Efficiency gains made
Strengthen technical capacity and country ownership		
Number of technical capacity assessments undertaken		Technical assistance calendars, tools and processes outlined for care and treatment
Number of Pathways-supported civil society organizations that received TA from SMART TA	5	5 PLPs selected with TA support from SMART TA
Number of health care workers who successfully completed an in-service training program	1,000	1,167
Number/type of coordinated TA provision		Clinical TA Google calendar implemented for SMART TA, HAIVN, CHAI and SCMS

Given the complexity of SMART TA, it is not surprising that a number of **lessons learned** will inform Year 2 (COP12 or FY13) of the program:

- SMART TA must build in ample time for *coordination and collaboration* efforts. We recognize that there are numerous challenges facing the program as we work together to actualize CoPC core and supplementary service package implementation and transitioning and technical assistance strategies. Coordination and collaboration must take place at national, provincial and district levels and involve GVN, CSO, community, multilateral and donor partners. Year 2 targets will therefore be realistic and strategic, to allow SMART TA to deliver on the most salient outcomes.

- GVN and CSO partners have initially been uneasy with the transitioning objectives of the SMART TA initiative. One response to this discomfort has been to suggest extensive cost savings through socialization approaches and cuts to existing programs. SMART TA must temper some of these suggestions with *realistic, evidence-based options* that protect the gains of the HIV response. GVN agencies will also require specific technical assistance in approaches such as professional case management for people who inject drugs, and peer-driven and/or social network interventions, so that they better understand the principles and strategies used in these approaches, and can adapt them to the realities in their particular provincial areas.
- *Transitioning strategies* among PEPFAR partners and across donor agencies (e.g. GFATM, World Bank/DFID) follow different timelines, approaches and priorities. While such differences are to be expected, SMART TA will work together with PEPFAR and LMG-TSP to foster open discussions about transitioning processes, key objectives, governance structures, strategies and benchmarks.
- As a result of *efficiency gains* advocated in the program, program implementers may respond by reducing educational contacts, limiting enrollment of clients into HTC, care and treatment or MMT services, or moving clients to different geographical locales. *Integrating services* – while important in terms of patient access and uptake – may further adversely reduce quality of care and provider motivation/satisfaction. SMART TA will continue to monitor provincial and district implementation closely to ensure that those who need services are able to access them in the places that are most suitable for their quality care.
- Recognizing the *interplay between strategic information and CoPC programming,* SMART TA believes that it is critical to involve technical and programmatic representatives in the identification of priority research topics. In Year 2, SMART TA CoPC technical staff will work together with strategic information counterparts to suggest operational research topics that will be coordinated with GVN, PEPFAR and other key stakeholders.
- With so many implementers, technical areas and policy directions, it is paramount to develop a coordinated *communications and advocacy strategy* to ensure synergy of efforts and facilitate overall impact of the response. SMART TA is committed to supporting PEPFAR, GVN and CSO implementing bodies in this endeavor.
- Access to, and uptake of, HTC continues to be adversely affected by *cumbersome HTC protocols, processes and procedures* that (a) make it impossible for those getting tested to know the outcomes of the test immediately, particularly those who have tested positive for the virus; and (b) make it difficult to facilitate repeat testing and linkages to care, particularly for services which are not co-located. SMART TA believes that renewed efforts must be made to advocate for a rapid testing algorithm (finger prick rather than venous)

and streamlined procedures regarding confirmatory testing. *Tracking of HTC uptake* also remains an issue across targeted provinces and sites, as the HTC referral systems across different donor-supported sites remain non-operational. Over the year, SMART TA will provide technical assistance to targeted PACs to strengthen referral networks and collect referral slips across sites.

- Challenges in *TA coordination* are the result, in part, of different methodological and management approaches toward provision of technical assistance at sites. They also result when organizations have different TA provision and evaluation priorities. In Year 2 of the initiative, SMART TA will work closely with PACs to articulate province-wide technical assistance and capacity-building plans that ensure TA is coordinated across TA providers and efficiently delivered.
- In a transitioning HIV response, GVN, CSOs, affected communities and the private sector all have a role to play. SMART TA will continue to work closely with Pathways and other key stakeholders to *harness the relative strengths and inputs* from different actors in priority PEPFAR provinces.

PROGRESS TOWARDS STRATEGIC OBJECTIVES AND PROGRAM INDICATORS

I. Deliver quality HIV services within the CoPC

Figure 4: SMART TA Objective 1 Interventions Strategy

SMART TA works with the GVN, PEPFAR and other key stakeholders to operationalize sustainable, efficient and evidence-based CoPC models in medium and low resourced provinces across the country. Three specific foci underpin Objective 1:

1. Reduce acquisition and transmission of HIV: strengthen the focus on MARPs
2. Reduce morbidity and mortality of PLHIV and improve quality of life
3. Provide targeted support for the generation and use of HIV-related strategic information (SI)

1.1 Reduce Acquisition and Transmission of HIV

While Vietnam has recorded a number of positive achievements in its HIV prevention response, ambitious 2015 national targets and declining donor resources demand a more targeted and robust response. Key challenges remain, including difficulties in identifying individuals most at risk for acquiring and/or transmitting the virus; articulating reach/penetration; over-reliance on free

commodities; deficiencies in the structural and policy environments; low treatment coverage; and the lack of long-term financing options. SMART TA works to address these and other key challenges with an intensified approach that strives to strengthen demand, uptake and coverage of critical and sustainable health and social services.

Strengthen demand, uptake and coverage of critical health and social services

In Year 1, SMART TA provided financial, programmatic and technical support to GVN and CSO implementing agencies to reach 24,952 female sex workers, 19,274 people who inject drugs, and 15,491 men who have sex with men with HIV prevention interventions across PEPFAR priority provinces. Table 2 represents HIV prevention programmatic performance over the annual period:

Table 2| Objective 1.1 program performance

Performance Indicator/Output	FY12 Target	FY12 (COP11) Achievements
Number of MARPs reached with individual and/or small group level interventions that are based on evidence and/or meet minimum standards required	**80,829 individuals** ▪ 30,740 PWID ▪ 17,751 MSM ▪ 32,338 FSWs	**59,717** ▪ 19,274 PWID ▪ 15,491 MSM ▪ 24,952 FSWs ▪ 730 PSP (PWID)
Peer-driven interventions trialed in at least 2 sites	Report with results by Q4	AIDS-free generation plus model drafted
Commodity distribution, social marketing and TMA plans developed with PSI and PACs	Plans/process articulated in sub-agreements	60% decrease in Protector Plus commodity requests from PACs
100% CUP interventions expanded in 2 provinces	Report on CUP program and expansion by Q4	CUP launched in Lao Cai and Nghe An
Number of needles and syringes distributed to people who inject drugs during individual or group-level interventions	*Target not set*	**1,391,026** MSM: 999 FSW: 16,501 IDU: 1,373,526
Number of pharmacies involved in needle and syringe programming	*Target not set*	467

Performance Indicator/Output	FY12 Target	FY12 (COP11) Achievements
Number of needles and syringes sold by designated pharmacies or other sales points	*Target not set*	483,469
Number of fixed boxes with N&S and condoms	*Target not set*	455
Number of condoms distributed to PWID, MSM and FSWs during individual or group-level interventions	*Target not set*	**797,795** MSM: 115,551 FSW: 389,255 IDU: 292,989
Number of condoms sold in SMART TA-supported entertainment establishments	*Target not set*	14,686 (An Giang only)
Number of lubricant sachets distributed to MSM during individual or group-level interventions	*Target not set*	25,721
Number of clinics offering opioid substitution therapy (MMT)	17	17
Number of people who inject drugs on opioid substitution therapy	3,200	3,606
Number/percentage of MMT sites where PITC/mobile HTC is integrated	14/82%	2/12.5%
Number of individuals who received testing and counseling services for HIV and received their test results	71,500	50,380
Number of service outlets providing counseling and testing according to national or international standards	36	34 (33 fixed with 50% offering mobile services; 1 exclusively mobile service)
% of MARPs reached who tested for HIV during reporting period	70%	Less than 10% (MSM/Can Tho) to 60% (PWID/Nghe An)
% HIV positivity rate of tested MARPs during reporting period	5%	7%
Number of people who use drugs availing HIV workplace interventions	60	127

Achievements in MARP HIV Prevention

- **Ensure targeted coverage of those at highest risk for acquiring or transmitting HIV.** In his May 2012 presentation to PEPFAR on Sustainable Peer Outreach Models, Michael Cassell stated that "who we reach is probably more important than how many we reach." Over the annual period, SMART TA supported provincial PACs and CSOs across 10 provinces to reach 59,717 MARPs with individual and small group-level interventions, or approximately 73% of the targeted annual total of 80,829 individuals (see challenges section for explanation of target shortfall). While reach was slightly lower than overall targets for the reporting period, the 7% positivity rate among those tested suggests that prevention implementers are reaching higher risk individuals in outreach efforts. SMART TA continues to focus on new and streamlined approaches to strengthen strategic targeting of evidence-based interventions in the second year of the program.
- **Introduce new approaches to strengthen coverage, improve quality and focus/systematize efforts.** In HIV prevention, quality is primarily defined by *what we do* (program and project content), *how we do it* (program approaches) and *what we achieve* (outcome and impact). Systematizing what we do and how we do it is critical as we move from project-focused to more program-oriented approaches across the country. In FY12/COP11, SMART TA focused primarily on "what we do" and "how we do it." We drafted a prevention core package document to frame discussions on priority services for MARPs in a transitioning response (see objective 2 for further information). We developed an "AIDS-free generation plus" model that uses new MMT clients to access high-risk drug using networks and HIV positive persons, particularly individuals not currently reached in HIV prevention efforts. The AIDS-free generation plus model will be presented to stakeholders in the first quarter of FY13/COP12 for further modification/endorsement and then trialed in two provinces. We reviewed ICT interventions (starting with internet outreach in HCMC) and put together an assessment tool to further identify digital usage and openings for application within the CoPC.

  SMART TA has worked with the HCMC PAC to revise and refocus the outdated transitions program for PWID in HCMC. The new program will strengthen the role of para-social workers to refer PWID to critical health and social services and provide case management support.

  In an effort to systematically define "reach" and ensure consistency among programs and sites, SMART TA has put forward the following working definition: "Reach = the provision of a standard set of interventions through outreach/case management/ICT that support high risk MARPs to seek and receive at least one of the core service elements at least one time per year." Because programmatic evidence in SMART TA (and likely other projects) suggests that HTC referrals and commodity promotion is not a regular part of all outreach interactions, we have also developed programmatic guidance for outreach contacts, called the 4 Ps (provide,

promote, perform, pass it on) that will be shared with GVN and PEPFAR in the coming quarter.

- **Coordinate condom distribution, social marketing and TMA plans in priority provinces.** Under the leadership of PSI, SMART TA worked closely with PACs to expand condom/lubricant social marketing and sales opportunities, and reduce reliance on free commodities through coordinated provincial-level forecasting and distribution planning. This was the first year that Protector Plus forecasting and distribution plans were decentralized to the provincial level, under PAC leadership. Provincial level condom coordination meetings--chaired by PAC Directors and attended by PEPFAR and non-PEPFAR partners involved in distributing condoms (all brands)--served as the forum to agree on which target groups and outlet types should continue to receive free condoms. Based on these agreements, PACs were asked to revise initial estimates for Protector Plus needs for the year. The result was a 60% decrease in Protector Plus commodity requests from PACs in FY12, versus the amount distributed in FY11 (requests in FY11 were made through implementing partners such as FHI 360).

  Together with other PEPFAR partners (such as USAID, HPI and PSI) and multilateral organizations, SMART TA has also played an advocacy role in the advancement of an inter-ministerial circular, which resulted in the scaling up of the 100% CUP. In August 2012, the draft of the inter-ministerial circular was further revised and sent to ministries for comments. And in August and September 2012, the 100% CUP was officially expanded in Lao Cai and Nghe An.

- **Strengthen and track the role of pharmacies in the sale of needles and syringes.** Over the reporting period, GVN implementing agencies identified 467 private pharmacies – up from 140 one year ago – to serve as "Safe and Friendly" needle and syringe sales outlets across 9 provinces. These outlets have sold approximately 483,469 needles and syringes to people who inject drugs. The sales figure represents a small but growing proportion of total needles and syringes sold or freely distributed through the program. Over FY13/COP12, SMART TA will work closely with PSI and PATH to develop a coordinated strategy in a targeted province (e.g. Hai Phong) that further increases commodity sales and tracks referrals to essential TB/HIV prevention and care services.

- **Expand access and uptake of MMT among people who inject drugs.** In FY12/COP11, four new MMT clinics opened in Hanoi (Dong Da district), Quang Ninh (Van Don district), and Hai Phong (Duong Kinh and An Duong districts). This brings the total of supported MMT clinics to 17, with approximately 3,606 individuals served (exceeding the annual target by 12%). SMART TA is now working closely with the GVN to open three more MMT clinics in Bac Giang, Lao Cai and the National Institute of Mental Health.

To foster continued uptake of MMT services, SMART TA has worked closely with SCMS and USAID to develop satellite-dispensing services linked to main clinic "hubs". The first MMT dispensing satellite in Vietnam has now been introduced in An Hung commune, An Duong district, Hai Phong. From May 2012, it has provided MMT for 113 stable patients. SMART TA believes that satellite services will (1) increase the number of people on MMT; (2) increase program efficiencies; (3) reduce total staff per patient treated; and (4) reward stable patients with convenient dosing privileges. In July 2012, SMART TA joined VAAC, USAID and SCMS in conducting a site assessment for a MMT dispensing clinic in Dien Bien, a mountainous area with cross-border traffic among drug users. The first MMT dispensing satellite in Dien Bien is expected to open in the first quarter of FY13/COP12.

- **Support the integration of selected HTC, ART and MMT services.** Three sites in Quang Ninh (Van Don), HCMC (District 8) and Dien Bien (Tuan Giao) now offer integrated HTC-ART-MMT services. Service integration has helped reduce overall staffing and operational costs, in addition to offering clients co-located, convenient services across the CoPC.

- **Increase the numbers of MARPs who are tested for HIV and retained in care.** During the reporting period, SMART TA supported 34 (including 1 mobile) GVN HTC sites that tested 50,380 individuals for HIV (see challenges section for explanation of target shortfall). Approximately 7% of these persons (3,551 cases) tested positive and 90% (3,143) were successfully referred to care and treatment services.

  Recognizing that viral load suppression is the paramount CoPC programmatic strategy for reducing HIV transmission and ameliorating the impact of HIV, SMART TA organized an internal "active case management" task force to analyze the CoPC cascade from prevention to care and to identify barriers and facilitators to HTC/care and treatment access, uptake and retention. This task force has now been expanded to include representatives from USAID, CDC and Pathways and a preliminary action plan has been developed to conduct further analysis and pilot strengthened CoPC interventions in one targeted province (Nghe An).

Challenges in MARP HIV Prevention

- **HIV prevention outreach overage is slightly lower** than the annual anticipated FY12/COP11 targets. SMART TA has identified a number of reasons for the shortfall, including the following:

  (a) *Mapping/size estimation data* for specific MARP subpopulations, such as people who inject drugs, recorded lower actual numbers than the annual targets. For example, PAC mapping data in the targeted provinces counted 21,000 PWID rather than the 30,740 annual targeted figures, suggesting that targets were ambitious.

(b) *Consolidation of sites and/or transferring of interventions* during the COP11/FY12 period, including consolidation of PWID outreach coverage from 13 to 5 wards in Can Tho; transfer of PWID and FSW interventions in Lao Cai to GFATM; and handover of interventions targeting drug user primary sexual partners (Dien Bien) and MSM (internet, Hanoi) to Pathways. While SMART TA will provide technical assistance to these sites (or to specific prevention components), we are not yet counting indirect reach of interventions funded by other donors, pending further guidance from USAID.

(c) *Expansion of MMT* in particular locales may have reduced the numbers of persons reached in HIV prevention interventions. This is particularly true in Haiphong, where 800 persons initiated MMT during the reporting period and we saw a subsequent reduction in PWID accessing harm reduction services, from 5,965 in the previous fiscal year to 4,558 in FY12/COP11.

(d) *Modifications to HIV prevention staffing structures/operations* as part of transitioning strategies reduced overall reach in specific locales. In Can Tho, for example, the PAC transferred its peer education network to the management of District Preventive Medicine Centers. Full time health educators – previously contracted under SMART TA to manage peer educators – were removed and their duties transferred to GVN staff. Targets and approaches were modified as per the Can Tho focus on "case management" and overall reach has subsequently declined, from 1,962 MARPs reached in the first six months of SMART TA to 752 MARPs reached after the introduction of a streamlined sub-agreement. SMART TA is reviewing the data across sites where structures and/or interventions have been streamlined and is developing targeted QI plans to reduce the impacts of transitioning (also see SMART TA service delivery case story "Staffing Workload Analysis of ARV-HTC-MMT clinics").

(e) *Late processing of sub-agreements* (in which staff/volunteer salary payments and referral mechanisms were disrupted) led to short term drops in reach in provinces such as An Giang and Can Tho.

Over the upcoming fiscal year, SMART TA will introduce approaches, guidelines and tools aimed at targeting those at greatest risk; expanding coverage to previously underserved clientele; clearly articulating "reach" and "contact" parameters; and using ICT technologies to ensure that key commodities and services are promoted to all MARPs.

- **MMT admission procedures continue to limit service access.** MMT admissions screening is not a permitted clinic function while the slow endorsement of the MMT Decree means that admissions remains a political filtering process. Access has been especially limited in Son Tay, Hanoi and Duong Kinh, Hai Phong. Together with PEPFAR, the UN and other key implementing partners like HPI, SMART TA will continue to play an advocacy role promoting community-based drug care and treatment, with an emphasis on MMT scale up and access.

- **HTC uptake targets have not been met.** While positivity rates suggest that higher risk MARPs have been tested, the overall target for HTC uptake was not achieved during the reporting period. SMART TA recognized this number was ambitious, but we believed that 71,500 individuals tested was achievable by strengthening service promotion, increasing coverage and expanding functional referral networks to ensure that referrals are tracked between different donor-funded projects. The work on these areas requires extensive collaboration and will continue into Year 2 as part of the strengthened CoPC "active case management" strategy and approach.
- **HTC promotion is not a systematic component of outreach contacts.** USAID has recently suggested that programs strive to support 70% HIV testing rates among MARPs reached by HIV prevention interventions. In SMART TA, the proportion of those tested among individuals reached varies enormously, from less than 10% of MSM in Can Tho to 60% of drug users in Nghe An (see Figure 5 below) – suggesting that outreach referrals are not a systematic part of outreach contacts and that numerous barriers stand in the way of testing:

Figure 5: Uptake Ratio by Sub-population and Province (Number of tests by MARP/Province: Number reached by MARP/Province)

While HTC uptake has not yet reached 70% of those reached, a few provinces/interventions did show improvements over the course of the reporting period such as PWID outreach in Hanoi and HCMC. Over the coming fiscal year, SMART TA will continue to work with PSI on HTC promotional efforts; advocate for rapid testing and mobile HTC services to facilitate access; distinguish newly tested from repeat testers (as possible); expand operational service referral networks in targeted provinces; and ensure that HTC referrals are regularly made during outreach contacts.

Plans for FY13 (COP12)

Priority activities for SMART TA during the upcoming fiscal year are as follows:

- Use a "cascade" analytical model to **review and evaluate current outreach approaches** in reaching MARPs, linking them to services, and retaining or re-engaging them in prevention programs. As part of SMART TA's "active case management strategy", this review will identify barriers and facilitators to CoPC access and uptake and include recommendations for programmatic improvements and/or revised interventions at site levels.
- **Develop and implement an action plan** for targeted interventions that increases recruitment, strengthens CoPC referral systems and service linkages, and retains/re-engages clients in care. Included in this action plan will be the development and introduction of **CoPC technical guidance and tools** generated from the cascade analysis. SMART TA expects to pilot the action plan and tools in Nghe An province, with possible expansion to first phase inter-agency transitioning provinces.
- **Reach 16,570 PWID, 18,230 FSWs and 13,800 MSM** with strengthened HIV prevention interventions.
- **Support 50,000 high-risk individuals to utilize HTC services** and receive their test results. SMART TA will work with its implementing partners to increase the proportion of those tested among individuals reached to achieve the 70% target and to ensure a 5% positivity rate.
- **Pilot new outreach approaches**. The program will trial alternative outreach approaches in select areas in order to compare the effectiveness and costs of different models. Building on the "AIDS-free generation"/"Change from within" peer-driven strategies drafted in Year 1, the program will pilot these interventions targeting MSM and/or people who use drugs in HCMC and Hai Phong and compare reach, service and commodity uptake with more conventional outreach models. In selected sites, SMART TA will utilize mobile and internet technologies to explore how they can complement face-to-face outreach models by increasing healthy behaviors, and reducing risks among MARPs in cost-efficient ways.
- **Expand MMT through fixed and satellite dispensing sites**: In FY13/COP12, SMART TA will collaborate with the VAAC, GVN and PEPFAR to provide MMT services to 5,500 people who inject drugs through 19 fixed MMT and three to five satellite MMT dispensing sites. In four districts, SMART TA will continue to work with implementing partners to integrate 3-in-1 service models (MMT, ART and HTC) or 2-in-1 service models (MMT and ART, or HTC and MMT), and to assess their relative efficiencies and effects on patient health outcomes. Specific sites will be designated as follows: [3-in-1: Bac Giang, Tuan Giao/Dien Bien, Binh Thanh/HCMC] and [2-in-1: Thuy Nguyen/Hai Phong, Le Chan/Hai Phong].

- **Integrate condom social marketing in selected HIV service delivery sites.** In Hai Phong and Can Tho, PSI and SMART TA will introduce socially marketed condoms in targeted OPC, HTC and MMT sites. Based on the success of this pilot, condom socially marketed efforts will be expanded to other HIV service delivery sites across PEPFAR priority provinces.
- **Apply 100% CUP.** SMART TA will work with 100% CUP implementation partners to support on-the-ground implementation; monitoring of the availability/accessibility of condoms at entertainment establishments (through peer educators); and participate in advocacy efforts among GVN ministries for scale-up and sustainability.
- **Refocus safe pharmacy NSP sales and distribution strategy**. In an effort to increase access to clean needles and syringes, SMART TA will review its NSP sales and distribution strategy and network, and focus efforts on top-performing safe and friendly pharmacies and non-traditional outlets. The program estimates that roughly two-thirds (68%) of the current network will receive more focused support to maintain consistent access during times when drug users need access to clean needles and syringes. Efforts will also be made to provide more enhanced training to these top-performing sites to provide quality referrals within the CoPC, in collaboration with PSI, PATH and the GVN.
- **Standardize operating procedures**: SMART TA will work with the VAAC, PEPFAR, CDC/LIFE-GAP, PSI, Pathways and other agencies to develop standard operating procedures that articulate norms (or acceptable ranges) for mapping, size estimation, staffing ratios, intensity of reach, salaries, and monitoring indicators and tools, based on the core service delivery package. Standard approaches will include targeted case management, coordinated referrals to HTC, MMT, and ART, commodity/service promotion strategies (condoms and needles), key messaging (knowing one's status; benefits of early treatment and partner disclosure; critical commodities), and retaining HIV-positive individuals within the CoPC.

1.2 Reduce morbidity and mortality of PLHIV and improve quality of life

While HIV care and treatment services have been scaled up rapidly in Viet Nam, barriers inhibit access to, and retention in services; affect quality of care; and limit sustainability of the HIV response. Current estimates suggest that 60% of PLHIV in Vietnam are accessing HIV care and treatment services. Of the remaining 40%, some have never been tested and do not know their status while others know their status, but have not accessed services or have dropped out of care. Many clients leave testing centers unaware or unconvinced of the benefits of long-term care, due in part to a lack of knowledge among counselors and clinicians about services within the CoPC. Despite gains in quality HIV service provision and referrals nationwide, many PLHIV are not able to navigate within the continuum of care. SMART TA is addressing these and related barriers through efficient, sustainable programmatic strategies that increase recruitment, improve referrals and retain or re-engage clients in treatment and care.

Improve access/retention, quality of care, coordination and referral linkages within the CoPC

In Year 1 of the program, SMART TA supported hospital and community-based HIV care, support and treatment services across 36 sites (including 2 GFATM sites receiving SMART TA technical support) for 16,778 PLHIV, including 12,479 on ART (3 sites provide care and support services only). Emphasis was placed on supporting MARPs and their sexual and injecting partners to access counseling and testing and, once they know their status, to immediately enroll in an HIV care and treatment or be followed up until enrollment has taken place. Over the first year of program implementation, SMART TA has achieved the following results:

Table 3| Objective 1.2 program performance

Performance Indicator/Output	FY12 Target	FY12 (COP11) Achievements
Number of HIV-positive adults and children receiving a minimum of 1 clinical service	15,540	16,778
Number of adults and children with advanced HIV infection receiving antiretroviral therapy	12,950	12,479
Number of adults and children newly enrolled on ART		3,000
Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	85%	88%
Number of eligible children provided with psychological, social or spiritual support	*Target not set*	1,699
Number of SMART TA-supported care and treatment sites receiving clinical mentoring and QI	34	34/34 (+2 GFATM supported sites that receive technical assistance)
Early enrollment from HTC-HIV OPC interventions piloted	2-3 sites	ACM strategy currently in development with PEPFAR partners
TB infection control site assessment and improvement plan undertaken with KNCV	Developed by Q4	(see achievements)
M&E and QI tools revised to be consistent with core service package and harmonized with GVN HIV care and treatment program	Revised by Q4	M&E indicators harmonized with GVN national indicator program. QI tools waiting for core package but harmonized under HIVQUAL program

Achievements in Care and Treatment

- **Increase the numbers of individuals enrolled into care and treatment services.** In 36 SMART TA-supported GVN sites, 16,778 HIV positive adults and children were provided with a minimum of one clinical service – exceeding the target of 15,450 individuals by 8%. Approximately 74% or 12,479 of these individuals also received ART.

- **Retain or re-engage clients in care.** Among 50,380 individuals tested for HIV during the first year of SMART TA implementation, 7% of these persons (3,551 cases) tested positive and 90% (3,143) were successfully referred to care and treatment services. In SMART TA-supported GVN OPC sites, 3,000 HIV positive adults and children were newly enrolled on ART across 34 care and treatment sites over the reporting period.

  Recognizing that viral load suppression is the paramount CoPC programmatic strategy for reducing HIV transmission and ameliorating the impact of HIV, SMART TA organized an internal "active case management" task force to analyze the CoPC cascade from prevention to care and to identify barriers and facilitators to HTC/care and treatment access, uptake and retention. This task force has now been expanded to include representatives from USAID, CDC and Pathways and a preliminary action plan has been developed to conduct further analysis and pilot strengthened CoPC interventions in one targeted province (Nghe An).

- **Enhance and sustain quality control systems for HIV care and treatment services.** In FY12/COP11, SMART TA worked with organizations such as CHAI and HAIVN to develop and use standardized clinical TA reporting forms in targeted sites, primarily in the south. Across the PEPFAR priority provinces, 34 sites received on site mentoring and monitoring support over the reporting period.

  Four SMART TA-supported GVN OPC sites were further selected to participate in the Stage 1 HIVQual-based National Care and Treatment Quality Improvement program piloted through VAAC. SMART TA care and treatment and SI staff served as TA providers and trainers during Phase 1, providing support in data collection, performance measurement, QI planning, and mentoring assistance. In FY13/COP12, SMART TA will align its quality improvement initiatives with Stage Two of the National Care and Treatment Quality Improvement Program. Stage two plans call for expansion to more than 70 sites in 16 provinces including those supported by CDC Life-GAP, CDC HCMC, SMART TA, Global Fund and the National Targeted Program. Included in this list of more than 70 sites will be all but two SMART TA-supported sites.

- **Develop and introduce tools and technical guidance for increasing and monitoring retention in and adherence to HIV care.** Focus during FY12/COP11 was placed on ensuring quality and minimizing adverse patient outcomes in HIV care and treatment as programs slowly transition from donor support. In addition to developing core package process documents (see Objective 2), SMART TA drafted an adherence toolkit consisting of an

adherence screening tool, an in depth adherence assessment, an adherence training package and adherence management tools. The toolkit was preliminarily tested in SMART TA-supported sites and is undergoing revisions based on site feedback. SMART TA will work closely with PEPFAR and VAAC over the coming year to finalize these materials and expand their use across care and treatment sites.

- **Strengthen TB diagnostics and treatment capabilities and practices.** SMART TA has expanded and consolidated its HIV TB work. We negotiated clear working mechanisms with KNCV/TBCAP, so that these USAID funded projects organizations work in tandem and benefit the other in the areas of potential overlap. For example, KNCV worked with SMART TA on the TB component of the provincial capacity building plans. SMART TA provided technical support to KNCV in developing research protocols and in reviewing the GeneXpert protocols.

  Within TB service delivery, SMARTA TA reviewed its case finding procedures and took measures to ensure higher levels of patient screening. IPT is not yet a routine programmatic activity, but SMART TA has provided technical assistance to VAAC in protocol development. SMART TA has participated in several small scale infection control activities in HCMC; has introduced an infection control component to the provincial work plan which has not yet been implemented; and early in Year 2 will be working with NTP and VAAC on infection control standardized roll-out and training.

  In terms of TB screening in MMT clinics, SMART TA has successfully piloted twice-yearly tuberculosis screening among 283 MMT clients in the District 8 (HCMC) clinic. SMART TA has supported the development of reporting forms and training materials and monitored uptake. In the next year, SMART TA will build on this experience and expand TB screening and MMT clinics nationwide.

- **Support the integration of selected HTC, ART and MMT services.** Three sites in Quang Ninh (Van Don), HCMC (District 8) and Dien Bien (Tuan Giao) now offer integrated HTC-ART-MMT services. Service integration has helped reduce overall staffing and operational costs, in addition to offering clients co-located, convenient services across the CoPC (see case story "HCMC District 8 integration").

- **Collaborate with partners to strengthen CoPC systems and approaches.** Over the course of the year, SMART TA worked with organizations/institutions such as VAAC, WHO, UNAIDS and Pathways to support the implementation of Treatment 2.0 in Dien Bien and Can Tho; develop national PITC and CITC guidelines; draft Pathways key programmatic components for CSO delivery grants, etc. These and other collaborative efforts will continue in the upcoming fiscal year.

Challenges in HIV Care and Treatment

- **Patient recruitment and retention continues to be problematic in some sites.** Across the country, patients initiating ART have low CD4 counts (median 90 in the ARV Outcomes study) and pre-ART patients have typically been eligible for treatment for extended periods before they eventually begin ART. Relatively low numbers of pre-ART patients in the clinic active patient list at any one point in time suggests that retention of patients during the pre-ART period is exceptionally low. As members of the ACM taskforce, SMART TA will review patient records in selected sites and work with GVN and other partners to strengthen CoPC linkages to improve patient recruitment, retention and/or facilitate re-engagement.
- **TB/HIV work is complex and challenging,** as a result of vertical systems and the large number of GVN and CSO implementers. SMART TA is dealing with this complexity by moving forward at a steady pace, ensuring that we keep all out partners fully aware of our plans and of our current and proposed activities. The end objective is not simply the implementation of the activities but also the development of the collaborative framework and relationships such that activities are implemented sustainably with support from domestic institutions.
- **Coordination of TA can be compromised** when TA providers are nearing the end of their projects. Instead of trying out new ways of working, these partners may place greater focus on program evaluation efforts. Some organizations are looking forward to the re-competition of their grants during 2013 and may even perceive FHI 360 as potential competitors. SMART TA's approach, as in other areas, is to work steadily, consistently, openly, and collaboratively; and as a result, to be seen as a trusted and reliable partner without hidden agendas. This reputation, once gained, is an extremely valuable and nonmaterial asset in building a technical assistance program.

Plans for FY13/COP12

- Use a "cascade" analytical model to **review and evaluate current care and treatment approaches** in retaining or re-engaging clients in care. As part of SMART TA's "active case management strategy", this review will identify barriers and facilitators to CoPC access and uptake and include recommendations for programmatic improvements and/or revised interventions at site levels. An initiative will also begin to better track patients in pre-ART, engaging with them to make sure they receive testing regularly, and directing them to care when necessary.
- **Develop and implement an action plan** for targeted interventions that increases recruitment, strengthens CoPC referral systems and service linkages, and retains/re-engages clients in care. Included in this action plan will be the development and introduction of **CoPC technical guidance and tools** generated from the cascade analysis and following on

from Year 1 materials such as the adherence toolkit. SMART TA expects to pilot the action plan and tools in Nghe An province, with possible expansion to first phase inter-agency transitioning provinces.

- **Support hospital and community-based care and treatment** across 34 sites for 16,500 PLHIV, including 13,950 on ART.
- **Increase, enhance and sustain quality control systems** for HIV care and treatment services by implementing and assessing the HIVQUAL model across 31 SMART TA-supported GVN OPCs.
- **Strengthen TB diagnostics and treatment capabilities and institute TB preventive therapy** for PLHIV and infection control for PLHIV and OPC staff. In FY13/COP12, SMART TA will provide TA for the development and implementation of training on the 3Is across GVN care and treatment sites supported by SMART TA.
- **Improve linkages and referral systems** between HIV prevention, HTC and care and treatment providers, programs and services. Currently, government and local partners have little knowledge about the success rates for referral mechanisms within the CoPC. With few data and scant feedback between providers within the network, it is difficult to determine where referral mechanisms most need improvement. Efforts to improve referrals to date have focused primarily on increasing the amount and kind of information clients carry with them to their referred service, and strengthening of services to which clients are referred. However, there is no universal tracking system in place that measures referral efficacy. To address this gap, SMART TA will work with PACs and CSOs to coordinate the development and use of mapping tools and exercises to identify where service uptake potential is greatest. In selected provinces (TBD), SMART TA will support provincial referral system consultations and help install systems at sites along the CoPC to strengthen, systematize and track referrals. Health and social services included within referral networks will be promoted through a variety of interpersonal and ICT channels. Referrals will be tracked using standardized slips and simple identifier codes. The program will also test promotional strategies that reward successful referrals and/or uptake.
- **Assist MoLISA to implement the National Program on Support for Children Affected by HIV:** SMART TA will provide technical assistance to MoLISA to implement the *National Program on Support for Children Affected by HIV* (2011-2015). Technical assistance will focus on case management approaches and family-centered care. The program will also support MoLISA in general capacity building and system strengthening, and to roll out the Thu Duc social work pilot.
- **Enhance PMTCT services and reach:** In FY13, SMART TA will continue to implement basic PMTCT service packages in Dien Bien and Lao Cai, both provinces with particularly high

prevalence of mother-to-child transmission of HIV. Technical assistance will focus on capacity building for GVN clinical staff. Support will help enhance referral for pregnant women living with HIV so that they are enrolled in the closest HIV OPC (which may or may not be an OPC receiving SMART TA support). Clients will be provided with clinical and CD4 assessment, ART for their own health and/or for PMTCT, and follow-up for exposed infants.

1.3 Provide targeted support for generation and use of HIV-related SI

SMART TA is working to address gaps in HIV-related SI by strengthening epidemic and outcome/impact monitoring; improving programmatic data quality and use; identifying and initiating priority research studies; and improving SI coordination and communications between VAAC, PACs, CSOs and other key stakeholders. Over the first year of program implementation, SMART TA has achieved the following results:

Table 4| Objective 1.3 program performance

Performance Indicator/Output	FY12 Target	FY12 (COP11) Achievements
Number of surveillance activities carried out with technical and/or financial assistance from SMART TA	3	3
QI tools revised and harmonized for HIV care and treatment	Drafted, Q4	Done. Harmonized the FHI 360 proposed QI tools for HIV care and treatment under a single National Care and Treatment Quality Improvement program
DQA tool and processes/protocols finalized	Tool/protocol developed in Q3	The tool has been developed and submitted to VAAC for approval
HIV MIS reviewed	4 meetings/year	MMT reporting review report and the revision of MMT reporting forms approved by VAAC and piloted
Data use and decision making improved at provincial levels	4 DDM Workshops and 4 DDM on-site coaching visits/year (with HPI)	2 workshop and 2 coaching visit conducted

Performance Indicator/Output	FY12 Target	FY12 (COP11) Achievements
Number of operational research studies conducted with technical and/or financial assistance from SMART TA	4	4
Number of articles submitted to peer reviewed journals	3	6 abstracts accepted at IAS
Number of annual epidemic bulletins and technical updates developed and disseminated in collaboration with GVN and stakeholders	4	0

Achievements in Strategic Information

- **Strengthen epidemic and outcome/impact monitoring.** Over the first year of programming, SMART TA supported VAAC and NIHE to conduct a training of trainers for staff from 31 provinces on the newly developed HIV Sentinel Surveillance integrated with brief behavioral questionnaires (HSS +). SMART TA also supported VAAC to provide training workshops on data analysis and report writing for HSS+ provinces. The workshops saw the attendance of M&E staff from 29 PACs in Vietnam. After the workshop, participants gained data analysis and report writing skills for developing the HSS+ report.

  In FY12/COP11, SMART TA worked with PEPFAR partners to assist NIHE to develop the IBBS Round III protocol. The IBBS will be implemented upon the approval of MOH which is expected in Nov 2012.

  In collaboration with the VAAC, WHO and UNAIDS, SMART TA finalized the draft report of the *National/Provincial HIV/AIDS Estimates and Projections Round III*. The report examines current, available epidemiological data in Vietnam and analyzes epidemic trends in addition to projecting the future course of the epidemic. This document will serve as a critical source of information for programming and planning.

- **Improve programmatic data quality and use**. SMART TA worked with a variety of partners to improve programmatic data quality and use at the site, provincial and national levels:

  (a) In FY12/COP11, SMART TA worked closely with CDC, Life-Gap, HAIVN, Hanoi School of Public Health, Global Fund, WHO to support VAAC to generate 10 core-QI indicators for measuring care and treatment performance as part of the National Care and Treatment Quality Improvement Program (HIVQual). In the first round of

performance measurement across 11 piloted OPCs, SMART TA provided TA to PAC and OPC staff to conduct the assessment, which was managed directly by GVN implementers in the second round. SMART TA also conducted two coaching/mentoring interventions to (1) train PAC and OPC staff on QI methodologies and development of QI action plans; and (2) monitor QI improvements at site levels.

(b) Nationally, SMART TA assisted VAAC to develop and pilot the national DQA tool and complete an assessment of the national HIV reporting system (D28). The DQA tool has been finalized and submitted to VAAC for approval. With regards to the development of the MMT MIS, SMART TA drafted an assessment report of the MMT reporting system that has been approved by VAAC. Revised reporting forms for MMT clinics also were approved by VAAC and are currently being piloted.

(c) At provincial levels, SMART TA worked with CDC and NIHE to complete the MARP Size Estimations study in Dien Bien, Can Tho and HCMC. SMART TA provided technical support to NIHE to conduct a training course on data analysis and data triangulation for 63 PACs as a means for developing provincial HIV epidemic profiles that can be used for planning and reporting purposes. We also continue to collaborate closely with HPI on the Data for Decision Making initiative. During the reporting period, SMART TA and HPI provided technical assistance for a DDM workshop on data communication in Hai Phong and a workshop on MARP size estimates for DDM provincial staff and one round of on-site mentoring in nine PEPFAR provinces. The program also provided technical assistance during the 5-Year GVN Strategic Planning Workshop in Can Tho and An Giang.

(d) At the site levels, SMART TA developed the VNIS360 online database to help the program manage key indicators across the program and facilitate analysis of triangulated data for QI purposes.

- **Identify and initiate priority research.** SMART TA carried out and/or finalized a number of important research studies in FY12/COP11, including the following:

  (a) Sampling method comparison study: The program collaborated with PHR to complete a study that compares different sampling methods for recruiting PWID in Hai Phong and MSM in Ho Chi Minh City. The draft report was completed and the results have been shared with partners and presented at the Regional Surveillance Workshop.

  (b) Staffing efficiency study: The program developed the protocol for a study to measure the efficiency of staffing based on different MMT clinic models with different patient loads, e.g clinics with 50 – 100, 150 – 200, 250 – 300 and more than 350 patients.

(c) *Barriers to enrollment in care study:* In collaboration with the VAAC, SMART TA finalized a qualitative study report on the facilitators and barriers to PLHIV enrolling and being retained in HIV care and treatment services in Vietnam, and disseminated the study findings/recommendations for program planning and implementation.

(d) *Rapid assessment on most-at-risk populations (MARPS) in Vietnam:* SMART TA conducted a qualitative assessment to: describe sexual risk and drug use behaviors among the target populations; identify facilitators and barriers to accessing HIV prevention services and commodities (e.g. condoms, lubricants and needles/syringes) among the target populations as well as recommendations on increasing access to these HIV prevention services and commodities; Using the findings of this assessment, recommendations for programs will be developed to improve access to and utilization of HIV prevention information, commodities and services as well as to facilitate positive behaviors among PWID, FSWs and MSM.

(e) *Costing exercises:* SMART TA developed a proposal for additional costing exercises at the site level that will be used to explore opportunities for increasing efficiencies. SMART TA is in discussion with local partners and with the VAAC to see how the results can best fit the needs of all stakeholders.

- **Improve SI coordination and communications.** Over the course of the first year, SMART TA had six SI abstracts accepted at the International AIDS Conference.

Challenges in Strategic Information

- All SI exercises rely on **extensive collaboration, consensus building and coordination** and this takes time and effort. Virtually all deliverables have been delayed as a consequence, be they protocols, reports, indicators, training packages and other tools.
- **DDM data can be difficult to interpret at district levels**. The DDM data – while useful at the provincial level – can be difficult to interpret at district levels. Data interpretation is also compromised by the fact that donors emphasize different indicators, unit designations, and data interpretation methods.
- **Health Management Information Systems (HMIS)** have not been systematically developed nor kept pace with program expansion. In the coming year, SMART TA will work closely with PEPFAR and GVN to develop clear processes and benchmarks for MMT MIS development.

Plans for FY13/COP12

- **Support IBBS Round 3 and HIV Sentinel Surveillance.** In Year 1, SMART TA worked with the PEPFAR SI technical working group and NIHE to develop the IBBS protocol for Round 3. In FY13/COP12, SMART TA will continue to collaborate with the VAAC, NIHE, PACs and other PEPFAR partners to support the third round of data collection and analysis. Similar to Round 2, the Round 3 IBBS will measure HIV and STI prevalence, and behavioral, demographic, and intervention exposure variables. The new design will take into consideration lessons learned in questionnaire design, sampling, and analysis from previous rounds, and focus on interpreting results for implementation partners. SMART TA will also work with GVN and local partners to support the HIV surveillance system, including HIV case reporting, and sentinel surveillance integrated with a short behavior questionnaire (HSS+).
- **Conduct HIV/AIDS Estimates and Projections.** In FY12/COP11, SMART TA worked with the East West Center to conduct the third round of HIV/AIDS Estimates and Projections for planning and evaluation purposes at the national and provincial levels. This coming year, SMART TA will support the GVN to update the 2012 estimates and projections, using AEM at both regional and provincial levels. SMART TA will also support the GVN to use additional, newly developed models to assess the impacts of HIV interventions in selected provinces (TBD).
- **Conduct MARP size estimation reviews.** In the first year of implementation, SMART TA collaborated with the PEPFAR SI team to support NIHE and PACs in Dien Bien, Can Tho and HCMC to pilot different strategies for MARPs size estimation. The results of these approaches are currently under analysis. In FY13/COP12, based on the analysis, SMART TA will work with the above partners to support the GVN to conduct MARPs size estimation consensus reviews (using available data) in at least three additional provinces. Results will help cater the CoPC model to the specific needs of targeted provinces, based on more accurate estimates of beneficiaries.
- **Strengthen national and provincial monitoring and evaluation systems, including MIS.** SMART TA will continue to work closely with the PEPFAR SI team, HPI, the VAAC, NIHE, Pasteur Institute, and Provincial AIDS Centers to strengthen the national and provincial monitoring and evaluation system, including data collection, analysis, triangulation, presentation, communication and data use for program planning and improvement. VAAC is currently developing a national M&E plan and SMART TA has fully supported and provided technical assistance in the development of a draft 28 core National M&E indicators. SMART TA will also work with GVN to further develop and operationalize the MMT MIS.
- **Build capacity for QI.** In collaboration with the VAAC, CDC/LIFE-GAP, Pathways and PACs, SMART TA will support the implementation of HIVQUAL, including the finalization of the Guidelines for National Care and Treatment Quality Improvement program (HIVQUAL) and

targeted capacity building. SMART TA will also engage the GVN and partners in developing prevention QI tools.

- **Perform data quality audits (DQA) and build DQA capacities.** In year 1, SMART TA supported VAAC to develop a national DQA tool. In COP12/FY13, SMART TA will develop and implement a DQA action plan and conduct DQAs in our supported-sites. SMART TA may also provide training for GVN and Pathways to build their capacity to conduct DQAs and independently analyze the data.
- **Conduct priority research,** in consultation with PEPFAR and GVN. Priority research studies currently include the following:

  (a) *Methadone clinic staff efficiency assessment.* Assess the efficiency of staffing structures for different MMT clinic models and measure staff working time on service delivery. This assessment will help GVN to estimate the minimal number of staff needed for different MMT clinic models, and to provide recommendations to improve staff efficiency.

  (b) *ICT assessment to strengthen CoPC linkages, improve efficiencies and sustain the HIV response.* In COP12/FY13, SMART TA will explore new technological vehicles (e.g. mobile phones) for providing intervention messages, improving adherence, reducing loss to follow up, tracking clients and collecting/reporting data.

  (c) *Outreach comparison study* in targeted provinces/sites. SMART TA will conduct a study to compare the effectiveness of two models of outreach (standard and peer-driven) in reaching MARPs and in changing behaviors, particularly looking at the use of HTC. The specific design of the study will be determined in consultation with USAID, CDC and other partners. The study was planned in Year 1, but due to an evolving discussion on outreach models, the study has been delayed.

  (d) *100% CUP evaluation*

  (e) *MMT service quality assessment* before and after transitioning in Hai Phong province.

II. Transition Financial, Administrative and Technical Ownership of CoPC Services

Figure 6: SMART TA Objective 2 Interventions Strategy

SMART TA works to incrementally transition financial and technical responsibility for its CoPC programming to GVN and CSO partners, based on systematic assessments of capacity, resources and effective implementation models that match local HIV epidemic needs. While there are a number of key components in a health systems strengthening response, SMART TA focuses primarily in three areas, in collaboration with other key transitioning partners such as CDC Life-GAP and, most recently, LMG.

1. Define, implement and monitor sustainable, cost-efficient and evidence-based core packages of HIV prevention and care and treatment
2. Transition management of programs, sites, services and interventions to GVN/CSOs in accordance with the USAID-approved timetable
3. Support transitions governance and management structures and advocate for adequate financing/resources

2.1 Define, implement and monitor core CoPC service packages

In a transitioning HIV response, interventions must be more economical, more impactful and more sustainable than ever before. Programs need to focus on what works; rapidly identify and integrate relevant innovations and technologies; and ensure that systems, delivery mechanisms and interventions can be ultimately sustained. In Year 1 of the program, SMART TA reviewed its CoPC interventions, services and structures and developed prevention/CHBC core service process documents and care and treatment QI tools (adherence toolkit) that can be used in CoPC core service consensus-building discussions with GVN, PEPFAR, CSOs and other key implementing or TA organizations.

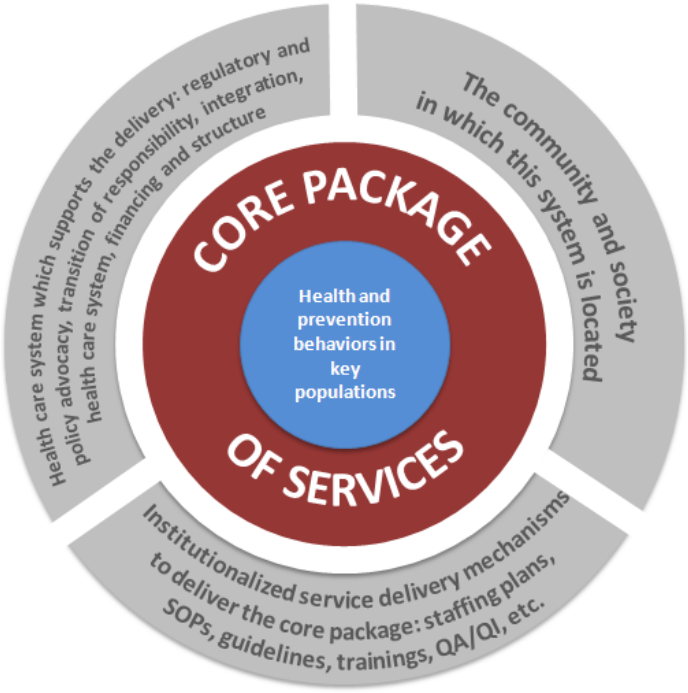


Figure 7: Core Package Services Circle

Accomplishments in Core Package Development and Consensus Building

The approaches for developing these tools varied by programmatic area; it was clear from the outset that a "one-size fits all" process for core package development across Prevention, Care and Treatment, and CHBC was unrealistic. Rather, each core package type first addressed the most pressing service delivery needs. The process of developing the HIV prevention core package, for example, initially focused on identifying *what* was included in the core service components. In CHBC, SMART TA first emphasized system/human resource issues *("who")*, given the current diversity of project-based staffing models, future roles of community-based providers, and unclear

future funding scenarios. The pressing quality assurance needs in HIV care and treatment, on the other hand, suggested that toolkits be prioritized to ensure that patients are retained in care and adhere to treatment. Despite the different starting points, the development of all CoPC core packages must address *What, Who, Where, How, How Often, By Whom, How Well (QA/QI)* (see Figure 8 below).

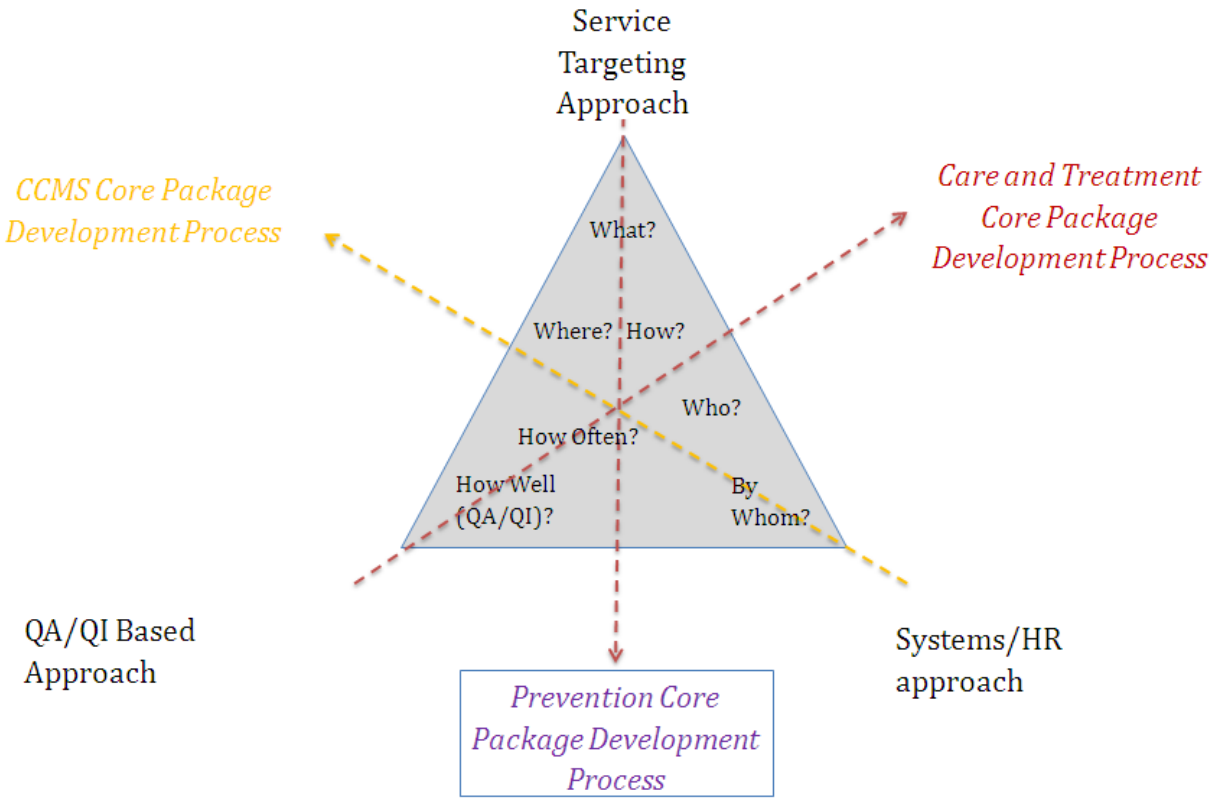


Figure 8: Core Package Development Process

During FY12/COP11, SMART TA shared core service approaches and parameters with PEPFAR, VAAC, UNAIDS and Pathways. Two, 3-day technical discussions with Pathways Project Lead Partners on prevention and CHBC core services were planned to take place in the first quarter of FY13/COP12. SMART TA is working with USAID to develop a strategy for moving forward on CHBC core package consensus building processes and also provides TA to VAAC to prioritize prevention core package consultations as part of its harm reduction action plan. The QI adherence toolkit is in the process of field-testing and is expected to be rolled out across programs in Year 2 of the initiative.

Challenges in Core Package Development and Consensus Building

While there have been a number of core package discussions/initiatives introduced during the year by PEPFAR, VAAC, World Bank, GFATM and others, there has been little **systematic review of components and defined processes** for reaching agreement across donor and implementing agencies. SMART TA believes that, by offering core service technical drafts that can be extensively reviewed and critiqued, GVN may more easily coordinate consensus-building strategies at the national and provincial levels.

Plans for FY13/COP12

- **Share and gain consensus on core CoPC service package parameters:** In Year 1 of SMART TA, CoPC technical staff defined parameters for core services within HIV prevention, CHBC, and care and treatment. The draft documents include information on key service components; delivery channels; frequency and intensity of coverage; recommended staffing ratios; estimates of unit costs; and summaries of priority tools and key indicators. To move these documents from SMART TA-owned materials to resources that can be used to develop Vietnamese-owned strategies requires work on a variety of fronts. SMART TA will participate in consensus building discussions within PEPFAR TWGs; support VAAC for facilitated consensus building discussions on CoPC core package contents, e.g current and alternative models and strategies, human workforce requirements for different models, SOPs, training packages, QI systems; support provincial consultations on different core package elements; and facilitate two consultations with LIFE and COHED to establish shared core package definitions and parameters (keeping in mind that CSOs may provide or link MARPs to additional services). It is expected that SMART TA will revise/update core package service documents during the consensus building processes and the ACM taskforce strategy development.
- **Build capacity to monitor core service delivery.** Once consensus has been reached on core package of services, SMART TA will review and simplify its existing M&E and QI tools and processes so that they better reflect the revised core services. M&E tools and processes are currently being harmonized with those under PEPFAR, VAAC, and the GFATM, namely the VAAC national M&E plan. Similarly, QI tools and processes will be harmonized with the VAAC HIV-QUAL QI system currently being piloted. SMART TA will provide technical assistance to VAAC to develop national M&E indicators and QI processes for areas not covered by HIV-QUAL.
- **Track costs and conduct targeted costing studies.** SMART TA conducted a cost analysis for SMART TA supported sites in Year 1. In Year 2, the program will continue to work with Urban Care, the VAAC, HMU and PEPFAR to build on existing costing studies and Data-for-

Decision Making (DDM) activities supported by SMART TA and HPI. SMART TA will generate site-specific cost data to increase prevention, care, and treatment site efficiencies. This will assist transition planning and help the GVN to allocate budgets.

2.2 Transition management of programs, sites, services and interventions to GVN/CSOs

In Year 1 of the program, SMART TA focused on understanding the GVN transitions "context" and preparing SMART TA GVN and CSO partners to transition through the following interventions:

Key achievements over the first year of programming include the following:

Table 5| Objective 2.2 program performance

Performance Indicator/ Output	FY12 Target	FY12 (COP11) Achievements
Province CoPC reviews completed in SMART TA-supported areas	11 provinces by Q2	11 provincial consultations conducted
Sub-agreement efficiency gains made across CoPC	20% across each sub-agreement	Agreement on efficiency gains by increasing the contribution from GVN resources and reducing overlaps among local implementers reflected in new sub-agreements
Implementation of PMTCT program transferred to GVN support	Achieved by Q4	Provision of complementary PMTCT services (before and after delivery) at Lao Cai and Dien Bien only
Proportion of funding for CoPC services provided by GVN in SMART TA supported provinces, e.g. staffing costs, operational costs	5%	
Number of dedicated and funded positions created by GVN to manage an appropriate HIV/AIDS response	*Target not set*	

Accomplishments in Transitioning

- **Eleven provincial CoPC consultations** in the Northwest Region (Lao Cai, Dien Bien); the North (Hanoi, Hai Phong, Quang Ninh and Nghe An); the Central region (Da Nang, Khanh Hoa), HCMC and the Mekong Delta region (An Giang and Can Tho) – were facilitated in collaboration with USAID/PEPFAR, Pathways and provincial health authorities. The consultations provided an opportunity to (a) consolidate and discuss CoPC interventions mapping data, with the intention of elucidating a "snapshot" of CoPC implementation across targeted provinces, irrespective of funding agency; (b) identify and discuss programmatic overlaps, inefficiencies, gaps and priorities in the provincial HIV response; and (c) foster and support collaboration across funding agencies and program implementers in HIV CoPC programming. Results from these provincial consultations were shared with all PEPFAR partners during a one-day consultation and later provided in hard copies.
- SMART TA developed CoPC narratives and budgets to be used as a basis for developing new **sub-agreements** with GVN and CSO implementing partners. These sub-agreements came into effect on July 1, 2012. They differed from previous agreements in a number of substantial ways: (a) there is greater focus on the broader provincial response, including mobilization of more resources from provincial authorities; (b) sub-agreement time frames and reporting are aligned with GVN processes; (c) sub-agreements outline efficiency gains and/or processes for efficiency gains over time; and (d) sub-agreements outline processes for the development of core/supplementary CoPC service packages.
- The **PMTCT program was transitioned** to the government with the exception of those programs in Lai Cai and Dien Bien, where it was considered that the recipients of transition did not have access to the required financial resources to continue the program of testing pregnant women for HIV infection. Given Dien Bien had the highest rate of maternal HIV in Vietnam, it was considered prudent not to risk collapse of the backbone of PMTCT services. In those areas in which transition has occurred, SMART TA continues to provide non-financial support and informal technical assistance to ensure that the post-transition services operate at a high functioning level.
- The **revision of the CHBC model** took place in FY12/COP11 while **transition of OVC programs** is occurring in incremental steps. The new sub-agreements saw the removal of financial support for school enrollment, children's play groups, un-targeted nutritional support (e.g. in situations for other than malnutrition), special children's events, and more comprehensive social support payments.
- SMART TA has worked with **Khanh Hoa and Da Nang PACs** on USAID phase out of HIV prevention interventions. This includes the development of a MoU (in the case of Khanh Hoa) and consultations aimed at preparing a **road map and transitions action plan.** Both provinces have actively advocated for the inclusion of MSM HIV prevention interventions

into the provincial 2013 budgetary plans; Khanh Hoa has agreed to contribute at least 150,000,000VND for MSM programming in the next fiscal year and will involve district-level HIV GVN staff in MSM program supervision, monitoring and support.

- **MMT sustainability measures** have been applied across MMT facilities supported by SMART TA. In FY12/COP11, SMART TA and GVN worked to reduce MMT operational costs by 20% (District 8 integration) and 30% in Hai Phong. GVN resources covered seven MMT staff across two clinics in Van Don, Quanh Ninh and Dien Bien. GVN support will be even more pronounced in Year 2 of the program, with Hai Phong assuming 70% of MMT operations costs and new clinics (e.g. Quang Tri, National Institute for Mental Health, Lao Cai co-pay) supporting all running costs, with SMART TA and USAID assisting with TA and methadone only.

  In collaboration with USAID, SMART TA worked with the Hai Phong PHS on the **MMT Co-Pay fee collection plan** to ensure future MMT sustainability. Fee collection conforms to important principles that ensure access and uptake, including not for profit orientation; reasonable patient contributions; free access for those who cannot afford to pay; and GVN guarantees to absorb more significant proportions of total MMT costs. The Hai Phong PHS has submitted the fee collection plan to the Hai Phong People's Committee and will apply these principles to all nine MMT clinics in the province once the plan is officially approved.

- In an effort to support high prevalence but underserved remote areas, SMART TA has worked with **Nghe An** provincial authorities to **extend HTC services** into two remote mountainous districts. SMART TA will support technical assistance, training activities and test-kits while the national program and local budget will cover all other human resources, operational and confirmatory testing costs. PAC technical officers will be supported to allow them to play a key role in providing immediate and long-term technical assistance to these sites. The sites will start providing service from November 2012.

- In **An Giang,** three OPCs (Tan Chau, Tinh Bien and Cho Moi) have **reduced** the number of **contracted staff** by 20% by integrating HTC-OPC services and replacing individuals with part-time hospital employees.

Challenges in Transitioning

- GVN and CSO partners have been **uneasy with the transitioning** objectives of the SMART TA initiative. One response to this discomfort has been to suggest extensive cost savings through socialization approaches and cuts to existing programs. SMART TA must temper some of these suggestions with realistic, evidence-based options that protect the gains of the HIV response.

- **Transitioning strategies** among PEPFAR partners and across donor agencies (e.g. GFATM, World Bank/DFID) follow **different timelines, approaches and priorities.** While such

differences are to be expected, SMART TA will work together with PEPFAR and LMG-TSP to foster open discussions about transitioning processes, key objectives, governance structures, strategies and benchmarks.

- As a result of **efficiency gains** advocated in the program, program implementers may respond by reducing educational contacts, limiting enrollment of clients into HTC, care and treatment or MMT services, or moving clients to different geographical locales. Integrating services – while important in terms of patient access and uptake – may further adversely reduce quality of care and provider motivation/satisfaction. SMART TA will continue to monitor provincial and district implementation closely to ensure that those who need services are able to access them in the places that are most suitable for their quality care.
- Transition is a complex process that needs **clear direction**, **guidance and oversight** from MOH/VAAC and PEPFAR. The establishment of national and provincial coordination structures with clear ToRs and mandates is critical.

Plans for FY13/COP12

- **Transition sites, interventions and/or management:** SMART TA-supported activities in Da Nang and Khanh Hoa will be phased out during FY2012 (FY13). Together with PEPFAR, the program will support PACs to develop and carry out a transitions strategy, including analyzing staffing and financial needs, articulation of technical assistance priorities, budget preparation, programmatic focus areas, identification of implementing partners, etc.

  SMART TA will also pilot transition of overall program management of two care and treatment sites in HCMC.

- **Monitor progress, client service uptake/retention and key service delivery indicators.** In provinces/sites/interventions where efficiencies have been made, SMART TA will closely monitor transitioning and selected key indicators to ensure quality and programmatic results. QI exercises, DQAs, and TA plans and protocols will be important components of this work.
- **Transition 70% of MMT staffing and operations costs to GVN,** in provinces such as Hai Phong. Ensure that any new sites have established sustainability measures before support is provided
- **Participate in transition toolkit development:** Virtually all PACs in PEPFAR priority provinces highlighted the need for a transitioning "toolkit" that includes provincial epidemiological fact sheets, resources, SOPs, etc. SMART TA will work with PEPFAR, LMG and VAAC to develop a dynamic toolkit that can be used across locales to guide transitioning efforts. The toolkit will serve as a key resource for national and provincial transition coordination task

forces and will outline possible roles and responsibilities during transition processes. SMART TA will focus on programmatic resources (e.g. epidemiological fact sheets; core package parameters, etc), while LMG will develop SoPs/ToRs for transition coordination task forces, budgeting procedures, etc.

- **Optimize staffing:** SMART TA will continue to work with VAAC, PACs, other GVN stakeholders and PEPFAR/LMG to articulate optimal staffing ratios and staff cost norms for the implementation and delivery of core CoPC service packages.
- **Consolidate sites and/or interventions:** SMART TA will continue to work with PACs and funders such as CDC-HCMC, CDC/Life-GAP and the GFATM to explore consolidation options in targeted provinces, with an initial focus on HCMC, Hai Phong, Da Nang and Can Tho. Consolidated sites or interventions may include drug use prevention programming in Ninh Kieu/Can Tho (to be consolidated with CDC-Life GAP program); sex work and drug use prevention interventions in Long Xuyen/An Giang (CDC-Life GAP); OPCs in D3 and D10, HCMC (CDC), and the FSW intervention in Ha Long city, Quang Ninh province (CDC Life-GAP).
- SMART TA will continue to negotiate with PACs to **refocus CoPC activities to reflect core service package parameters** and to reduce overall financial costs of sub-agreements in FY14/COP13, as per USAID-approved timetable(s).

2.3 Support transitions governance and management structures and advocate for adequate financing/resources

Financing options – including fee for service/socialization, health insurance and increasing GVN budgetary allocations – all require exploration as critical components of transitioning to country ownership. In FY12/COP11, SMART TA worked with PACs, VAAC and other relevant stakeholders to articulate appropriate staffing structures and to transfer some donor-funded personnel to GVN systems. The program also initiated efforts with Pathways to increase CSO engagement and closer collaboration with GVN systems. Key achievements over the first year of programming include the following:

Table 6| Objective 2.3 program performance

Performance Indicator/ Output	FY12 Target	FY12 (COP11) Achievements
Number/type of governance/management consultations organized with SMART TA support	*Target not set*	1/Know Your Systems
Transitions structures established and operational	Up to 11 by Q4	VAAC, PEPFAR and LMG to lead establishment
Number of provincial partnership agreements developed and signed	*Target not set*	5
Number/type of financing consultations organized with SMART TA support	*Target not set*	1/Health insurance consultation (An Giang)

Achievements in Governance and Financing Advocacy

- SMART TA, in collaboration with USAID, organized a one-day consultation workshop titled **"Know Your Systems – Furthering our Understanding of Key Systems in the Vietnamese Government."** The objective of this consultation was to provide necessary information on how health care prioritization/financing/budgeting is carried out at both central and provincial levels. The workshop was conducted in Hanoi on 10 February 2012. Guest speakers were Madam Do Thuy Hang, Vice Director General of the Public Finance Department of the Ministry of Finance; Dr. Nguyen Hong Son from the Personnel Department of the Ministry of Health; and Dr. Hoang Van Ke – Former Vice Chairman of the Hai Phong People's Committee. These guest speakers are high-ranking government staff and have great influence on personnel and financing issues for HIV programming in Vietnam.
- In order to raise awareness and facilitate commitment of provincial authorities (Provincial People's Committees and Provincial Health Services) with regards to the transitioning process, SMART TA worked closely with PACs to develop and sign five **Provincial Partnership Agreements** in Hai Phong, Quang Ninh, Nghe An, Khanh Hoa and HCMC. These agreements outline SMART TA roles and responsibilities and, in some cases, suggest possible funding reductions per year to allow provincial authorities time and parameters for HIV planning and actions.

- SMART TA has been involved in numerous consultations organized by MOH, VAAC, PEPFAR, UN and GFATM to identify transitioning scenarios/issues and to develop **resource mobilization strategies** for a sustainable HIV response.
- Approximately 179 HIV clients have been using **Health Insurance (HI) cards** for OI treatment and basic lab tests at the Tinh Bien OPC. The Tan Chau and Cho Moi OPCs have initiated HI application for their registered clients. This is very good starting point for transition of HIV treatment to GVN resources.
- **Advocacy for ARV resource mobilization**. Maintenance of a sufficient ARV drug supply for PLHIV in Vietnam becomes more challenging as donor funding declines. Advocacy for ARV resource mobilization is therefore a key priority now as it will take a significant amount of time for decisions to be made, sources of funding to be identified and plans to be approved. SMART TA has played a proactive role working closely with USAID and CHAI (Clinton Foundation), UNAIDS and CDC to support the OOG Advisory Board and VAAC Care and Treatment Department to develop reports and plans for ARV resource mobilization. As an important outcome of these collaborative efforts, a presentation on ARV resource mobilization was delivered by Mme. Hoang Thi Hien, Deputy Chief of the OOG Advisory Board at the National Assembly (NA) Workshop in Ho Chi Minh City on September 26, 2012. Following her presentation, the DPM requested a more detailed report with specific recommendations on the ARV issue. SMART TA, Clinton Foundation and USAID staff have helped to draft a report which was submitted to the DPM and is now under review. The impressive presentation to the Southern NA members has also raised increased interest from senior leaders of the NA's Committee for Social Affairs that they are now requesting VAAC and the OOG Advisory Group to join with ARV technical meetings and be involved in any new development of the national ARV plan. Under Vice Health Minister Nguyen Thanh Long's request, the action team formed by VAAC and international organizations, including SMART TA and USAID, is preparing a comprehensive and long-term ARV sustainability plan for the country.

Challenges in Governance and Financing Advocacy

- Not surprisingly, **GVN financing and support** remain the most pressing issue to tackle as programs move forward on transitions timelines. SMART TA will work closely with USAID, PEPFAR, LMG, the UN and others as we support the GVN at the national and provincial levels to identify and implement various financing options.

Plans for FY13/COP12

- **Strengthen CSO engagement in the response** by working closely with Pathways to provide TA/advocacy to facilitate CSO involvement in relevant national, provincial and district

structures, consultations and interventions. This may include: (a) advocating for the adoption of a cadre of peer educators and volunteers under the GVN system; (b) advocating for GVN subcontracting of CSOs to deliver HIV prevention interventions in specific locales; (c) including CSO/MARP representation and participation in key decision-making bodies such as the national and provincial transitions coordination task forces; (d) developing and trialing CoPC initiatives that require GVN-CSO partnership (e.g. community case management and support interventions); and (e) supporting GVN-CSO consultations (through civil society liaison bodies) at the provincial and district levels.

- **Advocate for increased budgetary allotments from the National Target Program:** SMART TA will support targeted provincial GVN representatives to help prepare financing advocacy materials, as above, that can be submitted as rationale documents in budget applications. While VAAC will develop the NTP Planning Framework for the period 2013-2015 with key support provided by LMG and PEPFAR, SMART TA can provide supplementary technical assistance as needed.
- **Expand health insurance coverage for PLHIV.** Currently, the socialized health insurance program does not work well for PLHIV. Procedures for "poor-cards" to get discounted premiums are cumbersome; enrollment is not available at the point of service delivery; social insurance is often tied to provision of care in the district of residence (e.g. care outside of district of residence is not always covered); and social insurance does not cover the cost of ARVs. Under the leadership of VAAC, PEPFAR, HPI, LMG and others, SMART TA will work to address these issues and support provinces to expand health insurance to those availing HIV care and treatment services. In particular, SMART TA will collaborate with HPI and VAAC on the health insurance assessment and consultation, provisionally planned for Q3, FY2012 (FY13). We will examine the feasibility of providing limited PEPFAR support for supplemental health payments among HIV positive clients who cannot afford to pay the 20% of un-subsidized costs in up to three provinces, and we will join in advocacy efforts to allow additional GVN-identified health facilities to issue and collect health insurance.
- **ARV financing and procurement capacity building:** Rising numbers of patients receiving ARVs and declining donor-funding necessitates that the Government of Vietnam be able to substantively finance ARV procurement; otherwise, the number of individuals able to receive continuous ARV treatment will be significantly constrained and drug stock outs much more common. This situation has serious implications for the progression of the HIV epidemic in Vietnam, as it known that early treatment with ART reduces morbidity and mortality, the social and human impact of HIV, and rate of spread of the epidemic. In FY13/COP12, SMART TA will participate in advocacy efforts that highlight ARV financing issues at this highest appropriate political level. Advocacy processes in this fiscal year will encourage GVN to systematically examine the obstacles currently in place which prevent effective use of national funds for ARV procurement and begin examining solutions and

mechanisms. SMART TA will work closely with the Advisory Board of the Committee 50, VAAC, Department of Public Finance (Ministry of Finance) and other relevant agencies to gather information, find problems and develop appropriate ARV financing models, in collaboration with other key partners such as USAID, Clinton Foundation, and SCMS.

III. Strengthen Technical Capacity and Country Ownership

Figure 9: SMART TA Technical Capacity Interventions Strategy

TA systems should perform four critical functions:

- Continually and critically examine emerging knowledge, technologies and innovative practices to determine which are the most relevant, feasible and likely to improve or sustain program effectiveness and capabilities
- Incorporate in-depth knowledge of evolving program needs and challenges
- Provide evidence-based assistance using culturally appropriate and efficient methods that lead to continual improvements in program coverage, effectiveness and efficiencies while building sustainable capacities and fostering local ownership
- Evaluate the quality, process, cost-effectiveness and impact of technical assistance to ensure its continued effectiveness.

SMART TA's technical capacity building strategy strives to fulfill the following aims: (1) to identify, develop and evaluate feasible, sustainable TA models in Vietnam and (b) to plan, develop, provide and assess technical support and mentoring for nationally owned and managed TA systems.

3.1 identify, develop and evaluate feasible, sustainable TA models

As the Vietnam HIV response transitions from external donor funding to country ownership, programs and implementing partners are requesting TA in areas ranging from program management, data analysis and use, and implementation across the CoPC. There remain questions about who is best placed to deliver TA, where TA will be "housed", and what TA services should have priority as programs adapt to changing situations and resource availability. SMART TA continues to work collaboratively and systematically to identify, develop and evaluate feasible, sustainable TA models in the country.

In Year 1 of the program, we have achieved the following results:

Table 7| Objective 3.1 Program Performance

Performance Indicator/ Output	FY12 Target	FY12 (COP11) Achievements
Number of technical capacity and needs assessments undertaken	*Target not set*	2
Key CoPC TA institutions identified and operational	*Target not set*	
Number/type of coordinated TA provision	*Target not set*	1/Care and treatment

Achievements in Development of TA Models

- **Assess *current TA capacities:*** SMART TA worked with Pathways to carry out technical capacity assessments of two PLPs in Year 1 of the program. In Year 2, SMART TA will revise its **Technical Organizational Capacity Assessment Tool** (TOCAT) to improve its usefulness within the Vietnamese context, and carry out TA capacity assessments with CSO service delivery grantees (in collaboration with Pathways PLPs) and targeted provincial TA providers (in collaboration with Lifegap, GFATM and others). We believe it is important for the tool to be adapted so that it is sensitive enough to show increases and decreases in technical capacity over time and actionable so that future TA can be directed to solve persistent or reoccurring technical weaknesses.
- **Coordinated care and treatment TA calendars** in selected provinces facilitated better provincial planning and use of TA across partners such as SMART TA, HAIVN and SCMS.

Challenges in Development of TA Models

Gary West et al. (2012) highlights the lack of an evidence base for TA in *"Defining and assessing evidence for the effectiveness of technical assistance in fostering global health"*. Particular challenges include:

- There is sparse evidence of effectiveness
- Best practices are usually not disseminated
- Successful and unsuccessful TA is often not documented
- TA outcomes are not subject to critical review and analysis
- Expensive TA models are often used

While SMART TA has developed a broad TA framework for a transitioning response, it needs to be context-specific and relevant to Vietnam's needs and strategic directions. SMART TA expects work on the adaptation of TA models and the identification of key TA institutions to be prioritized in Year 2 of the program.

Plans for FY13/COP12

- **Incorporate lessons learned** from CoPC program implementation into SMART TA training and TA services.
- Develop a system for **identifying relevant emerging technologies and innovative practices** and develop protocol(s) for adaptation, implementation and evaluation.
- Coordinate 3 provincial planning exercises to **identify TA priorities and needs.**
- Use the four pillars of **institutionalization, mentoring, credentialing and training** to develop, implement and strengthen TA systems in Vietnam.
- Utilize **coordinated CoPC TA calendars** in targeted provinces.
- **Develop and share "TA scenarios" paper(s)** and participate in consultations that identify CoPC TA providers/institutions at the national, provincial and district levels.
- Develop and present a proposal for a **credentialing process for TA providers** in Vietnam.

3.2 Plan, develop, provide and assess technical support and mentoring for nationally owned and managed TA systems

SMART TA works to support TA and move towards nationally owned and managed TA systems through the development of national, provincial and partner (Pathways) TA priorities and plans; and the provision of targeted training and capacity building, in collaboration with other key partners.

Over the course of the first year of program implementation, SMART TA has achieved the following results:

Table 8| Objective 3.2 Program Performance

Performance Indicator/ Output	FY12 Target	FY12 (COP11) Achievements
Number of SMART TA-supported provinces with provincial annual TA plans	3	Care and treatment TA protocol developed and introduced in Dien Bien
Number of Pathways-supported civil society organizations that received TA from SMART TA	5	2
Number of health care workers who successfully completed an in-service training program	1,000	1,167
Number of implementing partners provided with minimum package of technical and management capacity development assistance	36	34
Number of institutions that have received SMART TA technical assistance providing technical assistance to GVN or CSOs at the national, provincial or district levels	*Target not set*	2

Achievements in Technical Support Delivery

- **Provincial TA Plans.** As technical assistance becomes the focus of the PEPFAR program it will be increasingly important that TA is well planned, targeted to where the needs and opportunities overlap and is evaluated. In short, TA needs to be systematic. SMARTA TA has developed a standardized draft provincial capacity building plan which can be then be adapted over time to the needs of each particular province. This draft plan has several broad categories of technical assistance including clinical care. The clinical care component is designed to provide a framework for existing clinical mentoring and to provide additional activities to augment it. One of these additional activities includes the formation of a provincial clinical care training and supervision network, which is hosted and coordinated by

the PAC with involvement of local experts from the provincial hospital and SMART TA providing limited funding, technical support to the establishment of the system and to the individuals who contribute to it. The plan is that, where successful, this structure may be able to sustain the current clinical mentoring and other technical support activities as donor funding is eventually withdrawn. At this point this mechanism has been introduced in Dien Bien province only.

- Throughout FY12/COP11, SMART TA has provided support and **technical assistance to Pathways and its PLPs** in a number of areas, including selection of PLPs and CSO grantees; PLP workplan development; provincial GVN consultations, advocacy and program planning; core service package discussion preparation, etc.
- **More than 1000 health care workers** participated and successfully completed in-service training during the reporting period.
- **Response to ad hoc technical assistance requests.** A requirement for the provision of technical assistance is having standing amongst the community of recipients of that technical assistance. TA requests suggest that an organization is a trusted TA provider. During FY12/COP11, FHI 360 technical officers across the CoPC were called on multiple occasions to provide technical reviews, advice and assistance (e.g. HPI, PSI, SCMS, GVN, KNCV, Pathways, National TB Program, etc).

Challenges in Technical Support Delivery

- Current **TA is variable** in the ways in which it is targeted, delivered and evaluated across programs and partners. There has been variable willingness and availability of different organizations to participate in TA efforts and to accept SMART TA technical assistance when it is not directly linked to funding interventions.

Plans for FY13/COP12

- **Develop annual capacity plans** for first phase inter-agency transitioning provinces.
- **Develop TA strategies:** SMART TA will work closely with Pathways to develop a consolidated TA strategy for their PLPs and service delivery grantees over the life of the initiative. The TA strategy will outline a TA delivery structure, TA priorities, annual TA benchmarks, and a TA monitoring process that will be revisited each year. SMART TA will also draft TA strategies (similar to the FHI 360 MMT TA strategy) in HIV prevention, CHBC, and care and treatment for further discussion with PEPFAR and GVN

- **Provide *targeted training and capacity building for at least 500 GVN and CSO service providers:*** As part of the core packages and the ACM strategy development, training packages will be developed and/or updated in collaboration with partners and beneficiary groups, including VAAC, CDC/LIFE-GAP, Pathways, and MARP sub-populations. These training packages will be standardized at the national level with adaptable elements for provinces so that they are used across projects and donors and include the most up-to-date information on efficient and effective approaches with measurable quality standards. SMART TA will prioritize the 3-5 training packages (noting that the completion of materials will be linked with key TA priorities of VAAC, PACs and CSOs).
- **Advocate for restructuring of the GVN drug treatment approach:** In Year 1, SMART TA worked closely with HPI, PEPFAR and others to develop a broad policy paper and a number of policy briefs (sponsored by Atlantic Philanthropies) that were presented to the Office of the Government. Capitalizing on their feedback, FHI 360, SAMSHA and UNODC will coordinate a visit to Malaysia in FY13 for the GVN committee charged with 06 system restructuring and expects that this visit and other targeted advocacy efforts will move the country towards a community-based, voluntary, cost-effective drug treatment program.
- **Advocate for adoption of 100% CUP and expansion of community-based harm reduction approaches for FSW:** SMART TA is working closely with HPI, UNFPA, WHO and UNAIDS on improving sex work policy, in light of the approval of the *Law on Administrative Sanctions*. The informal committee - facilitated via the support of strategic consultations with National Committee representatives and other key GVN stakeholders - will advocate for the revision of the *Ordinance on Sex Work* to support widespread adoption of 100% CUP and the expansion of community-based harm reduction approaches for sex workers. SMART TA will also work with UNFPA to provide TA on harm reduction to MoLISA, adapting the FHI 360 *Drug Use and Society* curriculum for the sex worker context.
- Work with GVN, PEPFAR and other key partners to gain consensus on **CoPC training programs, TA providers, TA priorities and TA benchmarks.** Ensure that up to **60%** of SMART TA-delivered training and mentoring sessions are co-facilitated with recognized, local TA providers/institutions.
- Provide TA to **other donor-supported programs,** such as TA to 70 HIVQUAL sites.
- **Evaluate the quality and impact of TA efforts:** In FY13/COP12, SMART TA will work closely with PEPFAR, Pathways, VAAC and PACs to evaluate the quality and impact of TA efforts. TA tools will be prioritized, including the technical assessment tool (TOCAT) and a TA feedback tool, which implementers will complete following SMART TA-delivered capacity building measures. SMART TA will work with PEPFAR to identify areas where more rigorous TA evaluation work is needed to assess the competency of individuals/institutions in using new knowledge or technology to meet program goals and objectives.

- **Improve TA cost effectiveness:** Around the world, it is estimated that 40% of the costs associated with the provision of TA involve travel. In Vietnam, travel expenses for specific capacity building measures may run as high as 50-60% of TA costs. SMART TA will explore ways to reduce these costs in FY13/COP12 by (a) streamlining TA teams when training or mentoring is provided in the field; (b) working with local/provincial TA providers to co-facilitate capacity building measures; (c) conducting regional consultations among provincial clusters; and (d) introducing blended and/or e-learning initiatives.

PROJECT MANAGEMENT, PERSONNEL REQUIREMENTS AND CAPACITY BUILDING STRATEGY

Project Organizational Structure

SMART TA recognizes that its organizational structure must promote technical leadership in HIV prevention, care, treatment, and related SI, and forge linkages in the CoPC to break down barriers that hinder client access and uptake. To address these two challenges, the Program established a Technical and Capacity Building Structure and a CoPC Response Structure.

1. *SMART TA technical units* are composed of FHI 360 staff within specific CoPC, SI and Strategic Behavioral Communications technical areas. These teams outline core and supplementary CoPC service packages; provide overall technical oversight and QI; and offer TA that ultimately institutionalizes and sustains the HIV response.

2. *SMART TA response teams* are composed of FHI 360 staff across the CoPC. Teams provide overall programmatic and transitioning support to designated provinces within targeted regions. The regions are as follows: (a) Hanoi and the Northwestern Region (Lao Cai and Dien Bien); (b) Northern Region (Hai Phong, Quang Ning, Nghe An); (c) Central Region (Da Nang, Khanh Hoa); the (d) Mekong Delta Region (An Giang, Can Tho); and (e) HCMC. SMART TA also supports the central coordination of the response, through a sub-contract with the VAAC.

Project Staffing and Management

Chief of Party

Dr. Stephen Mills – previously the SMART TA COP – resigned from his position in FY2011 (FY12) to assume a new post in FHI 360's Asia Pacific Regional Office. Gary West has accepted the position of Chief of Party for FHI360's SMART TA program. All other SMART TA staff are in place and operational.

Project Management

FHI 360's previous vertical line management and staffing structure has been replaced by a matrix management system. As mentioned above, FHI 360 staff are members of cross-sectoral CoPC Response Teams and specific Technical Capacity Building Units. Each FHI 360 staff member is under the supervisory authority of a Response Team Leader and their technical supervisor. SMART TA Technical Advisors (e.g. Nick Medland, Suresh Rangarajan, and Peter Banys) report directly to the technical supervisor of their respective units. Job descriptions, office-seating arrangements, supervisory flow and coordination, and administrative processes have been modified to reflect this

new structure. FHI 360's performance management system (currently under review) will ensure that all staff are evaluated based on their contribution toward achieving the objectives of SMART TA (and other projects as assigned). The performance management system also assesses workload for each individual and strives to balance work-load requirements within and across organizational units.

The COP and Deputy COP manage and oversee overarching SMART TA program directions. As COP, Gary West has management oversight over the national-level transitions planning process and is involved in overall SMART TA strategy development. FHI 360's HSS Advisor reports directly to the COP, and the COP manages day-to-day transitions planning with the MOH, national transitions structures and USAID. The COP also provides general oversight of TA and capacity building for research and monitoring and evaluation, which is led by the Associate Director, Research, Surveillance and Evaluation

As Deputy COP, Caroline Francis oversees TA in the CoPC areas of prevention, care and treatment, and methadone. She also provides guidance and supervision to the provincial response teams to ensure meeting of agreed-upon benchmarks.

The Deputy COP and COP meet weekly to review program progress, troubleshoot issues, strategize and highlight key actions for follow up. The COP and Deputy COP further meet with the SMART TA AOR on a bi-weekly basis to ensure the smooth operations of the program.

SMART TA "Transitioning to TA" Staffing Strategy

As SMART TA transitions out of service delivery to technical assistance, the roles and responsibilities of our technical staff also change. In an effort to ensure that capacity to assess, deliver and monitor technical assistance is strengthened among all key technical staff, SMART TA has outlined the following roadmap:

Proportion of staff time allocated to service delivery, transitioning and TA components

In Year 1 of the program, emphasis was placed on (a) streamlining current service delivery components; (b) working with provinces to introduce them to the objectives of SMART TA and to develop new sub-agreements; and (c) developing CoPC core package process documents. SMART TA also worked with a HR company, Towers Watson, to articulate a matrix management system and to draft role profiles for all staffing levels (e.g. technical coordinator, senior technical officer, technical officer, etc). FHI 360 is currently undertaking a task management survey that will allow us to develop a performance-based management system to better manage and monitor work across the three SMART TA components. In FY13/COP12, we have proportioned the targeted time to be spent across each SMART TA objective as follows:

Staffing Category	Service Delivery	Transitioning	TA	Total %
COP/DCOP	35%	30%	35%	100%
Associate Director	35%	30%	35%	100%
Technical Manager	20%	30%	50%	100%
Technical Coordinator	20%	30%	50%	100%
Senior Technical Officer	20%	30%	50%	100%
Technical Officer	50%	20%	30%	
Associate Technical Officer	50%	20%	30%	
Technical Advisor			100%	100%

The proportion of time spent across each of the SMART TA programmatic elements will be reviewed and revised on an annual basis, to reflect the move from service delivery to TA.

Transitioning from Service Delivery to TA

During Year 2, FHI 360 will expand the process of transitioning out of direct support for service delivery and fully develop its TA System in which our staff assumes new roles as full time TA providers:

- The number of FHI 360 staff travel days to SMART TA service delivery sites will be **decreased by 25%.** This reduction will be accomplished through consolidating and increased coordination of monitoring and management tasks, including site visits and increased usage of e-learning initiatives.
- Staff with responsibilities for monitoring and managing service delivery sites will be **experienced health professionals** (MD, MPH and related professional degrees). They will be required to have had direct experience as clinical service providers or managers of service delivery systems in Vietnam. They will be training and mentored by FHI 360 and, where ever possible, will be **paired with PAC/DOH** staff to facilitate eventual transition to local ownership of site monitoring and management.
- **Site monitoring and reporting protocols** will be **standardized** and include checklists and other job aids to ensure that the utility of each site visit is optimized. Site visit scheduled frequency will be based on actual needs and experience of site staff. Sites that have been operating effectively for longer periods of time will be visited less frequently (every three to six months) while newer sites or sites with significant operational or performance issues or

turnover of key staff will be visited more often (once per month or every three months dependent upon actual need).

- A **review of the current FHI 360 training strategy, systems and curricula** will be undertaken. All site training will be based on an objective assessment of actual training needs and require clear, compelling justification before approval. Priority will be given to training that addresses operational priorities and problems across donor-funded programs. Training will be coordinated and, as feasible, consolidated or scheduled with other training to reduce travel and other costs. All training will be evaluated to assess its effectiveness.
- Actual **costs** for monitoring, site visits and training will be **closely tracked** and routinely assessed to identify opportunities for increased efficiency.
- In FY13/COP12, 2-4 sites will be identified for full **transition to PAC/DOH management** by the end of the year. Experience and lessons learned in transitioning these sites will inform procedures, protocols and other needs for successful, larger scale transitions of sites in subsequent years.

Also during Year 2, FHI 360 will continue its transition to full implementation of its TA model and systems by:

- Developing clear and viable **staffing plans** for all new initiatives and activities. FHI 360 has currently established task forces for new initiatives, including the community case management and support strategy; peer driven interventions; and new technologies and will share these staffing lists with USAID.
- Further developing and evaluating the staffing plan for full implementation of FHI 360's TA model and systems outlined under objective 3 including:

    - Assessment of current TA systems and efforts and staffing needs
    - Developing plans for further strengthening and systematizing TA methods and activities including procedures for routine evaluation and adapting TA methods to local situations and culture in Vietnam.
    - Ensuring that both pull and push TA activities are supported
    - Identification of priority TA needs at the national, provincial and local levels
    - Training, mentoring and coaching of TA staff (FHI 360 and partner staff) on how to be an effective TA providers in Vietnam
    - Train-the-trainer programs on how to be an effective TA provider for lead Vietnam institutions at the national, provincial and local levels
    - Knowledge management services fully developed to support the TA system and its TA providers

TA staff will be health professionals (MD, MPH or related academic degrees required) and will be fully trained and well supported. TA staff will need to have direct experience with and detailed knowledge of health programs and systems in Vietnam and understand common service delivery

issues and challenges. Mentoring and training skills will be required of all the TA staff.

INFORMATION ON COST OVER RUNS

No cost over-runs during reporting period

STORIES OF . . . TRANSITIONING FROM SERVICE DELIVERY TO TA

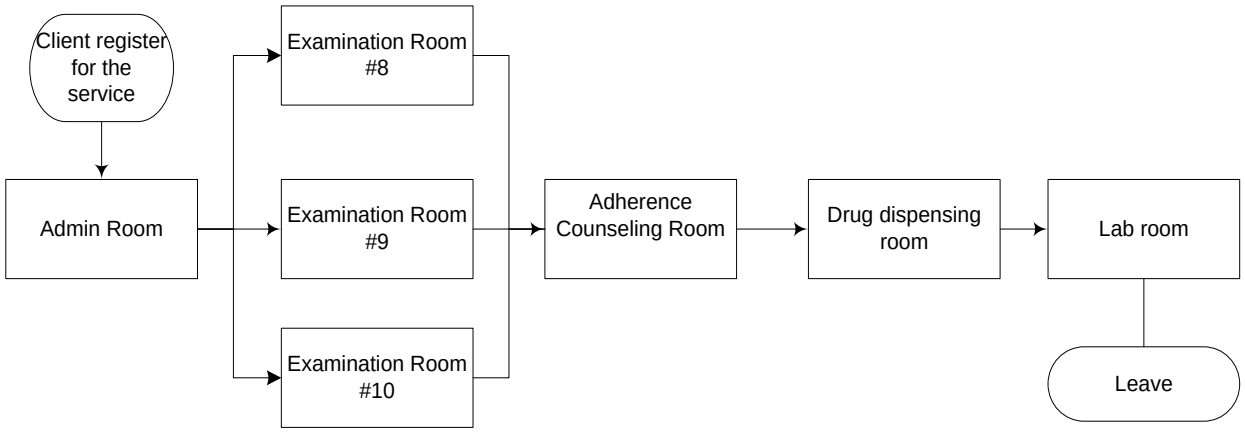
Service Delivery Stories

Staffing Workload Analysis of ARV-HTC-MMT clinics

SMART TA is now leading efforts to streamline and integrate HIV care and treatment, HTC, and MMT services to establish a more cost-effective and sustainable health delivery system in Vietnam. In January 2012, SMART TA conducted a number of meetings with the HCMC PAC to discuss a variety of approaches to reduce costs and improve quality across program sites. During these discussions, it became apparent that the most logical initial step toward optimizing cost efficiency would be a staff workload analysis, based on current work practices.

The HCMC PAC formed a special technical working group that included PAC, USAID, CDC, and SMART TA staff. SMART TA played the lead technical role in developing the methodology, tools, and framework for the analysis. The methodology is based on the adaptation of "lean" business management principles and focuses on the amount of time patients spend receiving services, and the type of tasks staff need to complete. The team determined this would be more appropriate than the "hatchet" or crude staffing/patient ratios approach commonly used to make staffing decisions. Data collection tools were created to follow different types of patient groups (categorized by service need) through each room in the clinic, depending on the typical flow of service by type (*see routine ARV patient visit example below*). Time of service at each station was recorded, aggregated, and analyzed to determine the amount of time required for each clinic to provide a specific type of service to a particular patient group. At the same time, the team observed staff as they conducted specific work tasks (direct contact, recording and reporting, etc.) to identify unnecessary tasks (minimal waste) and to infer which tasks could be relegated appropriately to the least skilled/least expensive staff (skill-mixing).

Sample Routine Care and Treatment Patient Flow (© = Observer of staff and patients)



Students from the HCMC School of Sociology were hired and trained to observe patients and staff. Patients were given colored neck cards based on their reason for attending the clinic (C&T, HTC, or MMT services) and then observed at each station by the students. As of August 2012, data were collected from five sites – Binh Thanh (USAID), Thu Duc (USAID), D6 (GFATM/CDC), D4 (CDC), and Phuan Nhuan (GFATM). SMART TA is now working closely with the HCMC PAC to analyze the data and quantify staffing requirements for each pilot site. Based on this information, the HCMC PAC will soon be able to make informed choices on staffing reductions, reassign staff to appropriate tasks, combine tasks as appropriate, and train staff to handle multiple tasks to optimize cost efficiency and service quality.

HCMC District 8 Integration

In December of 2011, SMART TA initiated collaboration with the Ho Chi Minh City PAC and District 8 Preventive Medicine Center to integrate ART, HTC and MMT outpatient clinics. Integration of traditional ARV with counseling and testing and methadone clinics has numerous advantages. Where successful, service integration can improve HIV testing and counseling among high-risk uninfected MMT clients, increase access to a broader set of services, and improve service quality, administrative processes, and cost efficiency. In addition, a single team of providers can address both HIV and MMT patient needs, reducing overall human resource requirements. The dual purpose teams can also maintain close relationships with patients, coordinate harm reduction counseling, and monitor adherence, drug-drug interactions, and side effects from both treatments. Combination services also increase efficiency by reducing space requirements, eliminating separate clinic visits and duplicate laboratory testing, and help build a cadre of providers with multiple skillsets.

Just prior to implementation of the pilot, the MMT clinic and OPC in District 8 were in separate buildings, but located at the same site. At that time, there were 223 patients at the stand-alone MMT clinic, and 1364 patients receiving ARV services at the OPC. The OPC was previously integrated with HTC, and tested from 120-140 clients per month. The number of full-time staff at the MMT, ARV, and HTC clinics were 17, 18, and 2, respectively (37 in total).

With the technical support from SMART TA, and in collaboration with the HCMC PAC, the District 8 Preventive Medicine Center initiated integration in January 2012. Start-up was slow due primarily to a lack of understanding of the rationale for integration, and resistance among providers to change job tasks across disciplines. To address concerns, SMART TA staff facilitated a number of stakeholder meetings to clarify the integration process and its short- and long-term benefits, which proved effective in alleviating concerns.

The team outlined specific functions for each staff member and trained relevant individuals to handle multiple functions. Doctors, nurses, pharmacists, MMT case managers, and ARV adherence counselors received cross-disciplinary training. Clinic flow and infrastructure were redesigned to triage patients appropriately, to make patient flow more efficient, and to congregate providers by function to promote information exchange and knowledge sharing.

As of August 2012, the District 8 PMC successfully integrated ARV, HTC, and MMT services into a single unit. In addition to improving the quality of services and patient flow, the PMC increased MMT/ART client load by 10%, and reduced fixed costs by decreasing staffing from 37 to 30. Building on this experience, SMART TA will support the HCMC PAC to integrate MMT and ART in two additional USAID-supported sites in HCMC next year.

The *Safe Pharmacy Initiative*: Engaging the private sector and the community in HIV prevention

The objectives of the *Safe Pharmacy Initiative* are to promote safe injection and service uptake (HTC), increase access to clean needles and syringes, and to diversify channels for behavioral change communication. The initiative works by engaging the private sector in HIV harm reduction and prevention, and by reducing stigma and discrimination at pharmacies and in communities towards people who inject drugs (PWID). Hanoi is one of the most recent provinces to initiate a *Safe Pharmacy Initiative.*

FHI 360 conducted an initial workshop in May 2011 to promote public-private collaboration, a shared vision, and to initiate registration for pharmacies as part of a "safe and friendly pharmacy network". The program conducted a follow-up workshop in October 2012 for pharmacy owners and staff on HIV/AIDS and harm reduction communication skills to improve HIV-related messages and services. Project staff conducted regular visits to pharmacies to provide supportive monitoring, and to collect data for program monitoring and evaluation.

As a result of the workshops, training and supervision, pharmacy staff and owners have become advocates and implementers of community HIV/AIDS harm reduction activities. They also understand the difficulties PWID face daily. Currently, there are 70 active safe pharmacies in Hanoi, providing services to over 2,000 PWID. As of September 2012, the pharmacies had sold over 75,000 needles and syringes and distributed over 600 referral cards for HTC. Of those referred to HTC from pharmacies, 78 individuals utilized the HTC services (of which 46% were new clients).

Experience from implementation in Hanoi has shown that explaining the harms of needle/syringe sharing and the risks of HIV transmission plays an important role in gaining commitment from pharmacy staff and owners. Active participation and training on innovative communication approaches for pharmacy staff are essential for successful HTC referral. However, despite changes in attitudes and skills, many pharmacy staff still continue to give priority to non-PWID customers, limiting the time they have to deliver needle/syringe safety messages and hand out referral cards.

In FY13, SMART TA will continue to promote the network and coordinate/collaborate with the Hanoi Office of Health, charged with managing pharmacies at the district level. The program will also encourage other pharmacies to participate. SMART TA will work with PSI and PATH to develop more effective promotion and marketing models for safe pharmacies. The program will conduct

quarterly experience-sharing meetings and provide awards to the most successful pharmacies to encourage engagement and commitment.

Transition Stories

Increasing government commitment and support for sustainable MMT in Hai Phong

The MMT program, initiated in 2008 with support from PEFPAR, WB, GF, FHI, and HAARP, is now undergoing unprecedented national scale up. By the end of September 2012, 49 medical clinics in 15 provinces and cities across the country were providing government-approved MMT services, with over 10,000 clients. In recognition of the benefits MMT programs have already made toward improving the socioeconomic situation in Vietnam, the GOV plans to expand MMT nationwide to provide treatment services for 80,000 clients by 2015.

Despite these successes, challenges remain in ensuring the GOV can provide sustainable services as PEPFAR support diminishes. US Government funding is currently scheduled to decline by 30% in 2012, 70% in 2013, and will go to zero by the end of 2014. The GOV initially expressed reluctance to use government finances to offset the decline in resources from international donors.

FHI 360 has played a leading role in bringing relevant players together to develop a transition plan amenable to the GOV and partners that will require minimal out-of-pocket payments from clients. The People's Committee of Hai Phong has shown strong support for MMT by approving *Decision No 1932/QĐ-UBND* in November 2011, which outlines a sustainable plan for MMT service delivery for the period 2011-2014. With support from FHI 360 and the People's Committee, the Hai Phong Financial Department approved funding to cover half of the running costs for MMT service delivery. Funding will go to all eligible MMT clinics in the city under the coordination of the Hai Phong Center of HIV/AIDS Prevention and Control. Financial support will cover operational costs, including personnel, coordination meetings, referrals and clinic renovation/maintenance.

As funds have begun to decline, FHI 360 and Hai Phong leadership have made considerable efforts to keep copayments and other out-of-pocket expenses low. One approach is the 50/50 funding mechanism, developed by FHI 360 and the People's Committee of Hai Phong, which will ensure that copayments are the same across clinics, and that MMT clients pay the same fee regardless of the level of service and drugs they receive. *Decision No 1932/QĐ-UBND* also provides a basis for increased funding support from the local government. Hai Phong has agreed to cover 50% of the costs, which, based on cost models, translates to 1.01 billion VND in 2012, 2.57 billion VND in 2013, and 3.90 billion VND in 2014.

Hai Phong is also pioneering an initiative, with FHI 360 support, to improve MMT health worker quality and retention by shifting from short-term contracts to long-term, government paid contracts. During the fiscal year, 28 out of 85 project staff who were working at MMT clinics in Hai

Phong were converted to government paid staff. This move will establish Hai Phong as a leading national example of sustainable MMT program delivery.

Decentralization of ARV dispensing in Thu Duc

During the initial stages of the HIV epidemic, PEPFAR and its implementing partners rapidly scaled up ARV distribution through a parallel, centralized treatment system. With declining donor funding, the GOV is now seeking ways to integrate the donor-funded ARV delivery system with the government-funded (decentralized) health care system, where service delivery is based at the commune level.

In September 2011, SMART TA collaborated with the HCMC PAC, CDC, and Thu Duc Preventive Medicine Center to pilot decentralized care and treatment with ARV dispensing for stable patients from district to commune levels. SMART TA worked with the HCMC PAC and CDC to develop criteria for patient transfer to commune health stations, and referral systems for patients to return to district level OPCs as needed. SMART TA also supported Thu Duc Preventive Medicine Center to implement systems for ARV quantification, distribution, and usage reporting, and laboratory monitoring between district and commune levels. The program facilitated adherence trainings for commune staff, and supported district level adherence counselors to provide ongoing technical support to commune staff both informally, and during scheduled monthly meetings.

Between September 2011 and September 2012, 149 stable ART patients were transferred to commune health stations (10) in 12 wards within Thu Duc District. The process faced some barriers, principally an unwillingness on the part of providers and patients to transfer care to the commune level. District doctors were reluctant to trust that patients could be followed up effectively by less trained commune providers, and they were wary about communication between communes and district OPCs. Patients were comfortable with their district care providers and were reluctant to move to the commune level. Early in the pilot, only 25% of eligible patients volunteered to be transferred to the commune level. However, transfer rates have increased during recent months, due to improved communication with patients and a growing understanding among district level providers of the long-term need to integrate care and treatment, including ARV dispensing, within the mainstream health system.

Based on the success of this pilot and a similar pilot in District 1, the HCMC PAC is moving forward with decentralization of ARV dispensing to communes in other districts, including USAID-supported District 8 and Binh Thanh clinics. With technical support from SMART TA and CDC, the HCMC PAC plans to train commune health staff in these districts in order to shift 25-50% of stable patients to the commune level for routine care and treatment and ARV dispensing by the end of 2014. SMART TA is currently supporting the development of a basic commune-level HIV curriculum, including ART and side effects, identification of opportunistic infections, assessment for ARV treatment failure,

and referral algorithms for patients who may need to be referred back to the district level for assessment and treatment. In the near future, SMART TA will build on these basic commune level training programs to create a sustainable ToT model in which all district level providers, including doctors and pharmacists, will be able to provide ongoing technical assistance to commune staff.

Technical Assistance Stories

Leading role of SMART TA in operationalizing national QI program

SMART TA collaborated with government partners and other technical assistance organizations to develop and support plans for the implementation of a comprehensive quality improvement (QI) system for Vietnam's HIV AIDS Care and Treatment program. Care and treatment programs are expensive and technically complex. Transitioning existing programs to government ownership and maintaining high service quality with lower overall budgets is extremely challenging. Putting in place a national quality improvement program across the entire program will be a large step toward consistently high care and treatment service quality irrespective of which donor supports which sites. It will also allow the effects of transition on service quality to be monitored and allow technical assistance providers and program managers to respond to changes in service quality in real time.

In the first year of the National Care and Treatment Quality Improvement Program, SMART TA has been an active technical assistance provider to government as it developed and piloted this system which aims to measure site performance, empower local service providers to improve the quality of clinical care and specifically measure the effectiveness of these QI activities. SMART TA worked alongside the government in adapting, developing and applying the QI tools including QI user guide, the minimum standard checklists, data collection tools, performance measurement analysis guides and quality improvement interventions. SMART TA worked closely with government as QI indicators were chosen and operationalized. SMART TA worked with VAAC to develop and implement the relevant forms and training materials.

SMART TA supported the government as they piloted the program in a stepwise manner: training sites in data collection, working with sites as they collected data from their own sites, training sites in performance measurement, working with sites to analyze their data, training sites in developing quality improvement plans and working with sites as they develop and implement their own quality improvement plans. In this pilot phase, 11 sites in 5 provinces participated. SMART TA provided technical assistance and support to the government led technical working group which in turn provided technical assistance to the provincial level authorities together with the individual sites.

This is a model for future technical assistance provision in which different agencies and organizations, in this case FHI360, CDC and HAIVN, provide support for a national program led by government. It was the culmination of the long term project initially led by CDC Vietnam. However, FHI360 is now being seen by government and by the other agencies involved as the primary driving force behind this program.

During the first year, SMART TA has been looking for opportunities to work closely with government to expand its technical assistance portfolio. Specific achievements include: evidence-based recommendations in the selection and refinement of 10 core QI indicators and subsequent data collection training materials, co-facilitating the trainings on performance measurements and data collection in all HIVQual selected cities/provinces such as Hanoi, HCMC, CT, Thai Binh and Thanh Hoa, and provision ofTA to develop the QI infrastructure and promote the QI philosophy for field coaching to OPCs and PAC QI coordinators.

The second year of the national QI program will see a substantial roll out of the system and SMART TA will be taking a collaborative "co-leadership" role side-by-side with our government colleagues. SMART TA negotiated with VAAC for an even closer collaboration in year two of the national QI program. Stage two of the national program will see this QI program encompass all SMART TA care and treatment sites, as well as CDC LIFEGAP, CDC HCMC PAC, Global Fund and National Program sites. This allows SMART TA to align its technical assistance plans with support for the national program. In short, support for the national program will be SMART TA's technical assistance in this area.

USAID-supported technical assistance will directly, tangibly and measurably improve the quality of patient care at 70 outpatient clinics, including those currently delivered through FHI 360, CDC, Global Fund and the Vietnam Government National Targeted Program.